

No. 93-1251-CFX
Status: GRANTED

Title: Donna E. Shalala, Secretary of Health and Human
Services, Petitioner
v.
Guernsey Memorial Hospital

Docketed:

February 1, 1994

Court: United States Court of Appeals for
the Sixth Circuit

Counsel for petitioner: Solicitor General

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12-28-93 ext til 2-1-94, J. Stevens, CITED.

Entry	Date	Note	Proceedings and Orders
1	Dec 23 1993	G	Application (A93-520) to extend the time to file a petition for a writ of certiorari from January 2, 1993 to February 1, 1994, submitted to Justice Stevens.
2	Dec 28 1993		Application (A93-520) granted by Justice Stevens extending the time to file until February 1, 1994.
3	Feb 1 1994	G	Petition for writ of certiorari filed.
4	Mar 3 1994		Brief of respondent Guernsey Memorial Hospital in opposition filed.
6	Mar 8 1994		Supplemental brief of respondent Guernsey Memorial Hospital filed.
5	Mar 9 1994		DISTRIBUTED. March 25, 1994 (Page 2)
7	Mar 21 1994	X	Reply brief of petitioner Donna E. Shalala filed.
9	Mar 28 1994		REDISTRIBUTED. April 1, 1994 (Page 12)
10	Apr 4 1994		Petition GRANTED. *****
11	May 19 1994		Joint appendix filed.
12	May 19 1994		Brief of petitioner Donna E. Shalala filed.
13	Jun 17 1994		Brief amici curiae of Hospitals Participating in St. John Hospital v. Shalala filed.
14	Jun 20 1994		Brief of respondent Guernsey Memorial Hospital filed.
15	Jun 20 1994		Brief amici curiae of Mother Francis Hospital, et al. filed.
16	Jun 20 1994		Brief amici curiae of American Hospital Association, et al. filed.
17	Jul 20 1994		Reply brief of petitioner filed.
18	Aug 2 1994		CIRCULATED.
19	Aug 17 1994		SET FOR ARGUMENT MONDAY OCTOBER 31, 1994. (2ND CASE).
20	Aug 29 1994		Record filed.
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21	Sep 6 1994		Record filed.
		*	Original record proceedings United States District Court for the Southern District of Ohio (BOX)
22	Oct 31 1994		ARGUED.

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No.

OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

**PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT**

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124 pp

QUESTIONS PRESENTED

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

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v.

GUERNSEY MEMORIAL HOSPITAL

**PETITION FOR A WRIT OF CERTIORARI—
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT**

The Solicitor General, on behalf of the Secretary of Health and Human Services, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Sixth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-14a) is reported at 996 F.2d 830. The opinion of the district court (App., *infra*, 15a-37a) is reported at 796 F. Supp. 283. The decision of the Administrator of the Health Care Financing Administration (App., *infra*, 40a-53a) and the decision of the Provider Reimbursement Review Board (App., *infra*, 54a-84a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 18, 1993. A petition for rehearing was denied on October 4, 1993. App., *infra*, 38a-39a. On December 28,

1993, Justice Stevens extended the time for filing a petition for a writ of certiorari to and including February 1, 1994. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in pertinent part as follows:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals

covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. * * *

2. The regulations of the Secretary of Health and Human Services implementing 42 U.S.C. 1395x(v)(1)(A), 42 C.F.R. Pt. 413, provide in pertinent part as follows:

Subpart B—Accounting Records and Reports

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

* * * * *

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

* * * * *

(b) *Definitions—*

* * * * *

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

3. Section 233 of the Secretary's Provider Reimbursement Manual is reprinted at App., *infra*, 85a-89a.

STATEMENT

1. Respondent Guernsey Memorial Hospital is a hospital that provides medical services to eligible Medicare beneficiaries, for which it is reimbursed by the federal government under the Medicare program. See generally 42 U.S.C. 1395c *et seq.* (1988 & Supp. III 1991) (Medicare "Part A"). For the 1985 cost year at issue in this case, providers like respondent were generally reimbursed for capital-related costs on a "reasonable cost" basis.¹

The Medicare Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. 42 U.S.C. 1395x(v)(1)(A). It directs the Secretary of Health and Human Services to promulgate regulations "establishing the method or methods to be used" for determining such costs. *Ibid.* The Secretary's regulations

¹ Since October 1, 1983, hospitals have been reimbursed for general inpatient operating costs under a system of predetermined rates known as the "prospective payment system" or "PPS." See 42 U.S.C. 1395ww(d) (1988 & Supp. III 1991); 42 C.F.R. Pt. 412; *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. 2151, 2155 n.3 (1993). Reimbursement for capital-related costs like those involved in this case continued to be made on a "reasonable cost" basis until the beginning of transition to a "capital PPS" system on October 1, 1991. That transition is scheduled to be completed by October 1, 2001. See 42 C.F.R. 412.304.

setting forth general principles of reasonable cost reimbursement are codified at 42 C.F.R. Pt. 413.²

In 1972 and 1982, respondent issued bonds to raise money for various capital expenditures.³ App., *infra*, 3a. The bonds were secured by mortgages on hospital property, bore interest at rates ranging from 5.25% to 12.5%, and were scheduled to have matured in full by 1996 in the case of the 1972 bonds, and by 2012 in the case of the 1982 bonds. See *id.* at 3a, 55a-56a; Admin. Rec. 770, 791. Outstanding bonds from the 1972 and 1982 series could also, at respondent's option, be repaid ("called") beginning in 1984 and 1992, respectively, in exchange for the payment of a "call premium" (prepayment penalty) in addition to the basic principal amount. See App., *infra*, 56a; Admin. Rec. 770, 791.

Both the interest payments on the 1972 and 1982 bonds and the costs associated with their issuance (such as underwriter's discounts and legal and accounting fees) were treated as allowable capital-related costs for purposes of Medicare reimbursement. See, e.g., 42 C.F.R. 413.130(a)(7), (a)(10) and (g); 42 C.F.R. 413.153. Interest costs on the bonds were incurred and reimbursed annually while the bonds remained outstanding. All of respondent's bond issuance costs, by contrast, arose in 1972 and 1982, when the bonds were issued. Such costs

² The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405 (1977), see 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (1986). Neither redesignation affected the substance of the regulations at issue in this case, and we refer to the regulations as currently codified, giving parallel citations only where they are useful.

³ The 1972 and 1982 bonds, like the 1985 refunding bonds discussed below, were actually issued on respondent's behalf by the City of Cambridge, Ohio. See App., *infra*, 56a; Admin. Rec. 440-535 (1985 trust indenture); *id.* at 770, 791, 936 (bond prospectuses).

are not recognized in full in the year paid, however, but are generally amortized as part of the provider's costs over the life of the bonds, for both financial accounting and Medicare reimbursement purposes. See App., *infra*, 3a-4a.

In 1985 respondent refinanced the 1972 and 1982 bonds in an "advance refunding" or "defeasance" transaction. In that transaction the bulk of the proceeds of new bonds issued by respondent, together with certain other funds, were transferred into an irrevocable escrow account established under the control of a trustee for the purpose of paying interest on the old bonds while they remained outstanding, and retiring them at a predetermined later date. See App., *infra*, 3a, 16a-17a. Under the terms of the old bonds, establishment and funding of the escrow account released respondent from any further obligation to the holders of those bonds. Aside from eliminating all restrictions imposed under the old bonds (such as mortgage liens and restrictions on additional borrowing), respondent estimated that refinancing with the new bonds, at interest rates varying from 6.5% to 10.5% (depending on the maturity of the individual bonds), would save it approximately \$12 million in debt service costs over the remaining life of the two prior bond issues. *Id.* at 3a, 16a, 56a.

Because the amount that respondent was required to pay into the refunding escrow account in order to defease all of its obligations under the 1972 and 1982 bonds exceeded the net amount at which those bonds were carried on respondent's books, respondent realized, at the time of the transaction, an accounting loss equal to that difference.⁴ App., *infra*, 44a, 56a-57a. The parties stip-

⁴ For these purposes the net carrying amount of the refunded debt consisted of the combined outstanding principal amounts of the 1972 and 1982 bonds, increased by accrued but unpaid interest, and offset by all of the original bond issuance costs that remained unamortized at the time of the refunding transaction. App., *infra*,

ulated that the amount of the loss was \$672,581. *Id.* at 17a.

2. a. For financial reporting purposes, respondent reflected the full amount of the refunding loss in 1985, the year of the transaction, in accordance with "generally accepted accounting principles" (GAAP), as set out in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (Accounting Principles Bd. 1972) (APB 26).⁵ See App., *infra*, 4a. Respondent also included the entire amount of the refunding loss in its Medicare cost report for that year. The "fiscal intermediary" responsible for review of respondent's cost report (see generally 42 C.F.R. 405.1803, 421.100) did not question the calculation of the total refunding loss, but determined that it could not all be claimed in the year of the transaction. That determination relied on a directive contained in the Secretary's Provider Reimbursement Manual (PRM), an extensive set of detailed guidelines issued to assist providers and intermediaries in applying the principles of reimbursement set forth in the Medicare

57a; see *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (Accounting Principles Bd. 1972). The difference between that amount and the amount that respondent paid into escrow—that is, the accounting loss recognized on the transaction—reflects not only the unamortized issuance costs, but also a call premium on the 1982 bonds (payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account) and the difference between the interest rates payable on the refunded bonds and rates prevailing at the time of the refunding transaction (which affected the amount necessary to fund the escrow account). See App., *infra*, 44a.

⁵ GAAP standards are set out in official pronouncements of professional organizations such as the former Accounting Principles Board or, since 1978, the Financial Accounting Standards Board; in the absence of an applicable formal standard, what is "generally accepted" depends on "the consensus of the accounting profession." App., *infra*, 4a n.1. See generally D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 2.4(a), 2.5 (7th ed. 1991).

regulations. See 1 & 2 *Medicare & Medicaid Guide* (CCH) ¶¶ 4600-8113 (1993).

Section 233 of the PRM, issued in 1983 and reprinted at App., *infra*, 85a-89a, applies to "advance refunding" transactions like that undertaken by respondent in 1985. Section 233 identifies the individual expense elements of an "advance refunding" transaction and specifies when such expenses are allowable for Medicare reimbursement purposes. It provides, for example, that while incidental expenses (such as legal fees) relating to the refunding transaction itself are allowable as soon as paid or accrued, call premiums are not allowable until the period in which they will be paid to holders of the refunded debt, and unamortized issuance costs of the refunded debt must be amortized over the period from the issuance of the refunding debt to the date that the refunded debt is actually retired. PRM § 233.3(B)(1), (B)(3) and (C); App., *infra*, 86a-87a. The overall approach of Section 233 is "to implicitly recognize any gain or loss incurred as the result of an advance refunding over [the remaining life of the old debt], rather than immediately." PRM § 233.3; App., *infra*, 87a.

b. Respondent appealed to the Provider Reimbursement Review Board (PRRB) (see 42 U.S.C. 1395oo(a); 42 C.F.R. 405.1835-405.1873), which reversed the fiscal intermediary's determination. App., *infra*, 54a-84a. Without directly addressing the validity of PRM § 233, the PRRB held that 42 C.F.R. 413.20 and 413.24 (formerly Sections 405.406 and 405.453, respectively) required that the allowance of costs for Medicare reimbursement purposes be determined according to GAAP. App., *infra*, 75a-76a, 82a.

c. The Administrator of the Health Care Financing Administration reversed the PRRB's decision. App., *infra*, 40a-53a; see 42 U.S.C. 1395oo(f)(1); 42 C.F.R. 405.1875. While recognizing that "GAAP can be useful in determining costs related to patient care," the Admin-

istrator rejected the PRRB's position that the Secretary's regulations required that GAAP be followed in all cases. App., *infra*, 45a-46a. Because under PRM § 233 "Medicare [had] a specific policy in effect governing the treatment of refunding transactions" during the year in question (App., *infra*, 46a), and because that policy recognized that the refunding loss was related to patient care provided in all of the years during which the original bonds remained outstanding (not merely in the year of the refunding transaction) (*id.* at 46a-47a), the Administrator ruled that for Medicare purposes the refunding loss should be treated in accordance with Section 233 of the PRM, rather than in accordance with GAAP.

3. a. The district court upheld the Administrator's determination. App., *infra*, 15a-37a; see 42 U.S.C. 1395oo(f)(1); 42 C.F.R. 405.1877. The court concluded that neither the Act nor the Secretary's regulations require adherence to GAAP for Medicare reimbursement purposes. App., *infra*, 31a-32a. In addition, the court held that the Secretary had "a rational basis for concluding that this particular loss should be amortized," and that the departure from GAAP in this case was therefore neither arbitrary nor capricious, because the Secretary's treatment would "more closely approximat[e] the impact of the [refunding] transaction upon the provider's cost of patient care." *Id.* at 32a, 33a.

b. The court of appeals reversed. App., *infra*, 1a-14a. It acknowledged (*id.* at 6a) that the Medicare Act does not require use of GAAP for reimbursement purposes. The court concluded, however, that two of the Secretary's regulations, 42 C.F.R. 413.20 and 413.24—which state that "[s]tandardized * * * accounting * * * and reporting practices * * * are followed" for Medicare purposes; that "[c]hanges in these practices and systems will not be required in order to determine" allowable costs; and that "cost data must be based on * * * the accrual basis of accounting"—effectively required that the Secretary

determine allowable costs in accordance with GAAP. *Id.* at 6a-7a. The court rejected the Secretary's construction of the quoted regulations: that they address only the manner in which providers must report their costs, and not the manner in which costs are to be reimbursed. *Id.* at 11a-13a.

The court recognized that there was "nothing irrational" about the non-GAAP treatment of advance refunding costs required by Section 233 of the PRM, and it had "no doubt" that the Secretary would have the authority under the Medicare Act to adopt it. App., *infra*, 8a-9a. But because it had interpreted the Secretary's more general regulations to require adherence to GAAP, the court held that to follow Section 233 of the PRM would "wor[k] a substantive change in existing regulations" and "impermissibly chang[e]" their meaning. App., *infra*, 9a, 10a. The court therefore viewed Section 233 as a "legislative" rather than an "interpretative" rule (*id.* at 9a), and held it "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it" (*id.* at 3a). The court accordingly remanded the case for entry of summary judgment against the Secretary on the advance refunding issue.*

* Both the district court (App., *infra*, 34a-37a) and the court of appeals (*id.* at 14a) also addressed a separate issue involving the treatment of interest earned by respondent on an account set up to accumulate funds for the payment of interest on the 1985 refunding bonds. Both courts ruled in favor of the Secretary on that question, and it is not at issue in this petition.

REASONS FOR GRANTING THE PETITION

The court of appeals erred in holding that in the absence of specific regulatory authority to the contrary, the Secretary's general Medicare record-keeping regulations require allowance, in a particular cost period, of all otherwise proper costs allocated to that period under "generally accepted accounting principles" (GAAP). Those principles are developed outside the Medicare context and outside the Department of Health and Human Services, and therefore cannot control the Secretary's exercise of discretion in administering the Medicare program.

The court of appeals' conclusion—that the Secretary has effectively delegated to the accounting profession her ultimate authority to determine the amount of reimbursement due a hospital under the Medicare program—conflicts with the decisions of at least two other courts of appeals. The question whether the Secretary and fiscal intermediaries are required to follow GAAP is also of substantial practical importance, for two reasons. First, its potential financial impact on the Medicare program is substantial. Second, there are serious and disruptive implications to the court of appeals' approach of interpreting broad and ambiguous statements of general regulatory policy to invalidate specific and sensible interpretative rules, designed to guide providers and Medicare administrators in their implementation of a large and complex governmental health benefits program. The decision therefore merits review by this Court.

1. The court of appeals' holding rests on its conclusion that two of the Secretary's general Medicare reimbursement regulations, 42 C.F.R. 413.20 and 413.24, mandate the use of GAAP to determine allowable costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue. App., *infra*, 6a-13a. That issue has divided the courts of appeals.

Decisions from two circuits arguably support the position taken by the Sixth Circuit in this case. In *Villa View*

Community Hosp., Inc. v. Heckler, 720 F.2d 1086, 1093 n.18 (1983), the Ninth Circuit stated that GAAP must control Medicare cost determinations in the absence of a contrary regulation, and applied that principle after concluding that regulations cited by the Secretary were inapplicable on the facts of the case. See also *National Medical Enterprises v. Bowen*, 851 F.2d 291, 294 (9th Cir. 1988) (rejecting Secretary's non-GAAP calculation of return on equity in the absence of a specific regulation); cf. *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1182 (9th Cir. 1989) (quoting *Villa View*).

In *Charlotte Memorial Hosp. & Medical Ctr., Inc. v. Bowen*, 860 F.2d 595, 598-599 (1988), the Fourth Circuit also noted the existence of conflicting positions on the issue of mandatory use of GAAP for purposes of Medicare reimbursement. While reserving final judgment on the question (*id.* at 600), it expressed the view that the Secretary would be "at the very limit of [her] authority" in prescribing accounting treatments that conflicted with GAAP, and in any event could not do so without showing that GAAP treatment would not "accurately reflect the cost of patient care." *Ibid.* (quoting *Villa View*, 720 F.2d at 1093 n.18).⁷

Other courts, by contrast, have held that the Secretary's general reimbursement regulations (including Sec-

⁷ The *Charlotte* court rejected the Secretary's non-GAAP treatment of certain deferred compensation amounts, after it concluded that the GAAP approach did accurately reflect the provider's cost of care. 860 F.2d at 601. A number of district courts have also accepted the mandatory-GAAP argument in the specific context of advance refunding transactions. See *Methodist-Evangelical Hosp., Inc. v. Shalala*, No. 92-2887-LFO (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235, 1242-1244 (C.D. Ill. 1993), appeals pending, Nos. 94-1098 & 94-1099 (7th Cir.); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139, 141 (W.D. Ky. 1991); *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338, 344-345 (N.D. Ill. 1985); *Mercy Hosp. v. Sullivan*, [1992-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 40,227, at 30,602-30,603 (D. Me. 1991).

tions 413.20 and 413.24) do not require the Secretary to apply GAAP in determining what costs are allowable under Medicare in a given reporting period. In *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, cert. denied, 469 U.S. 823 (1984), for example, the Fifth Circuit upheld the Secretary's non-GAAP treatment of certain "stock maintenance" costs, observing that what is now Section 413.20 "is directed at the type of financial data and reports required of providers," and "is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs." 725 F.2d at 328-329 (quoting *American Medical Int'l, Inc. v. Secretary of HEW*, 466 F. Supp. 605, 623-624 (D.D.C. 1979), *aff'd* on other grounds, 677 F.2d 118 (D.C. Cir. 1981)). Similarly, in *Methodist Hosp. of Indiana, Inc. v. United States*, 626 F.2d 823, 826-827 (Ct. Cl. 1980), the court upheld the Secretary's refusal to allow certain pension costs, holding that "[n]either th[e] statute nor the regulations requir[e] that the Secretary find that a cost is reasonable and actually incurred simply because it is an accrued liability for accounting purposes."⁸ The court of appeals for the District of Columbia Circuit has expressed the same view, albeit in dictum. See *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130, 135 (1982) (Bork, J.).

Finally, the Ninth Circuit has also rendered decisions (both before and after those, cited above, that are consistent with the decision below) that support the Secretary's position on the application of GAAP accounting. See *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701, 706 (1980) (Kennedy, J.) (mis-cited in *Villa*

⁸ See also *Mother Frances Hosp. v. Shalala*, 818 F. Supp. 990, 994-995 (E.D. Tex. 1993) (advance refunding), appeal pending, No. 93-4388 (5th Cir.) (argued Jan. 31, 1994); *Queen's Medical Ctr. v. Sullivan*, 797 F. Supp. 821, 824-826 (D. Haw. 1991) (noting conflict in Ninth Circuit decisions and construing both regulations in favor of Secretary); *American Medical Int'l, Inc. v. Secretary of HEW*, 466 F. Supp. at 623-624.

View, supra); *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542, 547 (1990) (“[GAAP] procedures promote uniform recordkeeping; they do not prescribe reimbursable costs”), cert. denied, 111 S. Ct. 2014 (1991). While such an intra-circuit conflict is not in itself a ground for further review, along with the conflict among the other courts of appeals it serves to demonstrate the confusion that has arisen in the lower courts over the question presented. That widespread confusion merits resolution by this Court.⁹

2. The court of appeals erred in concluding that the Secretary is required to apply GAAP in adjudicating Medicare reimbursement claims, in the absence of a specific regulation to the contrary.

a. The court of appeals acknowledged that the Medicare Act itself imposes no such requirement. App., *infra*, 6a. Indeed, the Act explicitly delegates to the Secretary the authority and responsibility to “establis[h] the method

⁹ There is not yet a conflict among the courts of appeals regarding mandatory application of GAAP in the precise context of advance refunding transactions, although the issue is presented in that context in cases that are now pending in the Fifth Circuit, *Mother Frances Hosp. v. Shalala* (see note 8, *supra*), and Seventh Circuit, *Graham Hosp. Ass’n v. Sullivan (Shalala)* (see note 7, *supra*). The Fifth Circuit has already sustained the Secretary’s position on the GAAP issue in *Sun Towers, Inc. v. Heckler*, *supra*, and presumably will adhere to that position in *Mother Frances*. In any event, the advance refunding cases turn on the broader issue of whether the Secretary’s general regulations require application of GAAP in all contexts not covered by a specific regulation. There is accordingly no reason to await developments in the advance refunding cases in other courts of appeals. That is especially so because if review is denied in this case, the Sixth Circuit’s decision will require resolution against the government of a similar case, involving a group of almost 30 hospitals, now pending in that court. *St. John Hospital v. Shalala*, No. 93-2334 (briefing stayed pending filing of the government’s petition for a writ of certiorari in this case). The significant amount of money at issue in *St. John* will be irretrievably lost if review is deferred to await the development of a more specific conflict.

or methods to be used, and the items to be included, in determining [allowable] costs,” and provides that in establishing those methods the Secretary

may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for use of different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on * * * costs * * *, and may provide for the use of charges or a percentage of charges where this method reasonably reflects * * * costs.

42 U.S.C. 1395x(v)(1)(A). Given that broad and flexible mandate to the Secretary, it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare statute, to abdicate to the accounting profession (or to anyone else) the ultimate responsibility for making particular cost reimbursement determinations. The court of appeals’ contrary interpretation of the regulations now codified at 42 C.F.R. 413.20 and 413.24 is implausible for that reason alone.

The court of appeals remarked on the fact that the Act requires the Secretary, in prescribing cost-determination regulations, to “consider * * * the principles generally applied by national organizations.” App., *infra*, 6a (quoting 42 U.S.C. 1395x(v)(1)(A)). The court read that provision as directing the Secretary to consider such organizations’ general *financial accounting* principles, and specifically GAAP (which the court felt that it could “safely assume” such “national organizations” would apply). App., *infra*, 6a. The court, however, elided the remainder of the statutory phrase: “or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to pro-

viders of services on account of services furnished to such recipients by such providers." In context, the statutory language plainly refers to the *reimbursement* principles developed by national insurance or prepayment organizations in the health services sector (although those principles would, of course, have a significant cost accounting component).

During hearings on the original Medicare legislation, Social Security Commissioner Ball stated that his agency would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). *Medical Care for the Aged: Executive Hearings Before the House Comm. on Ways and Means*, 89th Cong., 1st Sess. Pt. 1, at 142 (1965). Later, in proposing the first set of Medicare regulations, Commissioner Ball reported that, in conformity with the statutory provision quoted by the court of appeals, he had consulted with representatives of the AHA and similar groups. 31 Fed. Reg. 7864 (1966); see also *Reimbursement Guidelines for Medicare: Hearing Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 45, 59, 61-63, 197-198 (1966); *1st Annual Report on Medicare*, H.R. Doc. No. 331, 90th Cong., 2d Sess. 39-40 (1968). Neither the AHA pamphlet, nor either of the two subsidiary publications on which it relies, refers to GAAP as a guiding principle of hospital reimbursement. See American Hospital Ass'n, *Principles of Payment for Hospital Care* (rev. Aug. 1963);¹⁰ AHA,

¹⁰ The pamphlet states (at 6) that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting"—a general principle similar to that eventually adopted by the Secretary in what is now 42 C.F.R. 413.20. As the pamphlet's explanatory comment goes on to state (at 6-7), however, "[h]ospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments for third-party purchasers. * * * Only through uniformity of records and reports can third-party agencies be assured that they are paying for similar services in

Uniform Chart of Accounts and Definitions for Hospitals (1959); AHA, *Cost Finding for Hospitals* (1957). The available evidence thus confirms what is in any event the natural reading of the statutory language: that the "principles * * * applied by national organizations or established prepayment organizations" that the statute requires the Secretary to "consider" have nothing specifically to do with GAAP.

b. The language of the regulations relied on by the court below (App., *infra*, 6a-8a) provides no more support for its holding. The more detailed of those regulations, 42 C.F.R. 413.24(a) (originally codified at 20 C.F.R. 405.453(a) (1967) and reprinted at page 3, *supra*) specifies only that most providers must support their claims for Medicare reimbursement with "adequate cost data" based on "an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. 413.24(a). The court of appeals evidently read the requirement that cost data be reported "on the accrual basis of accounting"—rather than on the basis of cash receipts and disbursements—to entail automatic imposition, in every detail, of the *particular version* of accrual accounting embodied in GAAP. App., *infra*, 7a-8a.

The court's interpretation would be strained even if the regulation itself provided no definition of its terms. In fact, however, Section 413.24(b)(2) does provide a specific definition:

Accrual basis of accounting. Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

different hospitals on comparable bases." (Emphasis added). As with the regulatory language discussed below, those statements are directed toward the "uniformity of records and reports" required of providers, not toward whether particular costs are appropriate for reimbursement in particular periods.

That definition nowhere mentions GAAP, the Accounting Principles Board, or any other specific source of accounting authority, which could have been easily referenced had the regulation's drafters intended to incorporate it into the general requirement of accrual accounting.¹¹ In any event, Section 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary (or a fiscal intermediary acting on her behalf) in determining which costs are allowable under Medicare in any given period.

The more general provisions of 42 C.F.R. 413.20(a) (reprinted at page 3, *supra*) provide equally little support for the court's analysis, although their purpose and effect are more ambiguous. Originally placed at the end of a series of essentially prefatory sections of the initial Medicare regulations, see 20 C.F.R. 405.406 (1967), Section 413.20(a) provides:

¹¹ The text of APB 26 itself establishes that the amortization of advance refunding costs required by PRM § 233 (see App., *infra*, 85a-89a) is consistent with any general requirement to use "accrual accounting." APB 26 adopted as part of GAAP the immediate-recognition treatment used by respondent in this case. The opinion makes clear, however, that before its issuance a considerable body of professional opinion supported the amortization treatment embodied in Section 233 as the correct "accrual accounting" treatment for all or most debt-for-debt refundings. See APB 26, ¶¶ 5-6, 10. Indeed, one APB member who concurred in the opinion (and two of the dissenters) specifically disagreed with its requirement of immediate recognition in the case of debt refundings like that at issue here. See *id.* (statement of individual views). See also *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, Statement of Governmental Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993) (adopting amortization method of accounting for refunding losses reported by proprietary activities—including hospitals—operated by state and local governments).

The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Because of its broad terms and its placement in the original set of regulations, it is unlikely that Section 413.20(a) was ever intended to do more than provide general reassurance to providers contemplating participation in the Medicare program, and to alert a reader to the record-keeping and cost accounting requirements set out in more detail in what later became Section 413.24.¹²

In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles. And of particular relevance here, Section 413.20(a) states that the methods for determining allowable costs under Medicare "involve *making use of data available* from the [provider's] basi[c] accounts, as usually maintained, to arrive at" proper reimbursement—not that those methods involve accepting the provider's final cost accounting figures (whether GAAP-based or otherwise)

¹² The original regulations included both an introductory and a later, more specific section to cover each of several major points. Those sections were generally relocated adjacent to each other in the 1986 recodification (see note 2, *supra*). Compare the correspondence between original Sections 405.406 and 405.453 (now 413.20 and 413.24); 405.405 and 405.454 (now 413.60 and 413.64); 405.403-

without further adjustment in light of the purposes and requirements of the Medicare program. As in the case of Section 413.24, the regulation is directed toward ensuring the existence of provider records sufficient to enable the Secretary and fiscal intermediaries to calculate the costs allowable under Medicare, not toward prescribing how that calculation will be made. Compare, *e.g.*, 42 C.F.R. 413.53 (specifying detailed rules for apportionment of costs between Medicare and non-Medicare patients); 42 C.F.R. 413.134-413.149 (specifying allowable depreciation costs).

At most, Section 413.20(a) is ambiguous with respect to the imposition of any requirement that a provider's books conform to GAAP—let alone that figures recorded in accordance with GAAP be accepted, without further justification, as representing costs that were properly incurred in a given period for purposes of reimbursement under Medicare. Even granting that doubtful ambiguity, however, the Secretary's longstanding interpretation of her own regulations is certainly neither "plainly erroneous" nor "inconsistent with the regulation[s]," and it is therefore entitled to "controlling weight." *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993) (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)); see also *Martin v. OSHRC*, 499 U.S. 144, 150-151 (1991). The court of appeals erred in failing to respect that fundamental proposition.

c. The Secretary's position that GAAP does not control the appropriate treatment of particular costs for reimbursement purposes is sound not only in general, but also in the particular context involved in this case. It is a central concern of "reasonable cost" reimbursement under Medicare that any costs allowed should be properly matched to services provided to the program's beneficiaries. That

405.404 and 405.452 (now 413.50 and 413.53 (Section 405.404 has no current counterpart)); and 405.402 and 405.451 (now 413.5 and 413.9).

principle alone makes it important to allocate costs that relate to more than one accounting period (like most capital costs among the periods when the corresponding benefits will be realized. See, *e.g.*, 42 C.F.R. 413.130(c) (amortization of cost of capital improvements); 42 C.F.R. 413.134-413.144 (depreciation of capital assets)).

Proper periodic allocation is all the more necessary because allowable non-specific costs are apportioned to Medicare in each accounting period based, in general, on some measure of the overall use of hospital facilities by Medicare (as distinguished from non-Medicare) patients. See generally 42 C.F.R. 413.50-413.56. Thus, shifting costs among reporting years can significantly affect the costs appropriately borne by Medicare—if, for example, a provider's Medicare utilization rates fluctuate significantly from period to period, or if the provider chooses to withdraw from the program entirely before all benefits of some previously incurred cost have been realized. Proper periodic allocation also helps to ensure compliance with the statutory and regulatory prohibition against "cross-subsidization" between Medicare and non-Medicare patients. See 42 U.S.C. 1395x(v)(1)(A)(i); 42 C.F.R. 413.5(a), 413.9.

In the context of the Medicare program, it is the responsibility of the Secretary to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods. The discussion of various possible approaches—including the alternative reflected in PRM § 233—in the text of APB 26 itself (see APB 26, ¶¶ 5-7) demonstrates that the Secretary may reasonably conclude that the advance refunding loss recognized by respondent for financial reporting purposes in 1985 in fact represented costs associated with providing health care services throughout the life of the old financing arrangement, and should therefore be amortized over the remaining term of the old bonds for purposes of Medicare reimbursement. Indeed, the court of appeals acknowledged that the Secretary could properly follow that ap-

proach. App., *infra*, 8a-9a. The court ruled in respondent's favor on the sole ground that the Secretary's reasonable treatment of the particular costs at issue here was precluded by what the court believed to be a regulatory requirement that she observe instead the alternative treatment selected by the Accounting Principles Board.¹³ Because, as discussed above, the court erred in discerning any such regulatory requirement, the Secretary's concededly rational treatment should prevail.

3. The court's basic error in interpreting the Secretary's regulations also gave rise to its equally erroneous conclusion (App., *infra*, 3a) that Section 233 of the PRM "effects a substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." As we read the court's opinion, that conclusion has no force independent of the court's determination that the Manual provision, which was issued without notice or comment, conflicts with a GAAP accounting requirement embodied in Sections 413.20 and 413.24 of the regulations; in the absence of any such conflict, the court of appeals would presumably have recognized Section 233 as a valid elaboration of the regulations' other provisions concerning the determination of reasonable costs. Nonetheless, in the event that the court's APA conclusion might instead be read as an independent holding (rendered without the benefit of brief-

¹³ APB 26 makes clear that the Board's selection of the immediate-recognition alternative was largely the result of striving for consistency between debt-for-debt refundings like respondent's and other early retirements of debt. See APB 26, ¶¶ 16-19. The decision of course gave no consideration at all to the particular context of a government (or other third-party) health care cost reimbursement program. This Court has previously recognized, in the tax context, that standard financial accounting practices may not adequately serve legitimate governmental objectives. *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522, 542 (1979). Compare also GASB Statement No. 23 (cited at note 11, *supra*).

ing by the parties), we have included it in the questions presented and address it briefly here.

Under the Administrative Procedure Act (APA), substantive or "legislative" rules may not be issued without prior notice and the opportunity for public comment. 5 U.S.C. 553(b) and (c). The APA, however, explicitly exempts from its notice-and-comment requirements various kinds of lesser administrative action, including the issuance of "interpretative rules" and "statements of policy." 5 U.S.C. 553(b); see, e.g., *Lincoln v. Vigil*, 113 S. Ct. 2024, 2033 (1993).

Courts have recognized that the categories of "interpretative" as opposed to "substantive" rules "have 'fuzzy perimeters' and establish 'no general formula.'" *Batterton v. Marshall*, 648 F.2d 694, 702 (D.C. Cir. 1980) (footnote omitted). To make the distinction, the courts have asked whether the rule "impos[es] a new substantive obligation," *McCown v. Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), cert. denied, 479 U.S. 1037 (1987), or creates "new law, rights or duties." *Friedrich v. Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), cert. denied, 498 U.S. 817 (1990) (quoting *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985)). If so, it is substantive. See *Alcaraz v. Block*, 746 F.2d 593, 613 (9th Cir. 1984). Interpretative rules, on the other hand, "merely clarify or explain existing law or regulations." *Seldovia Native Ass'n v. Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990). "[I]nterpretative rules are statements as to what the administrative officer thinks the statute or regulation means" when applied in particular situations. *Gibson Wine Co. v. Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952).

Applying these standards, and on the assumption that Sections 413.20 and 413.24 do not require adherence to GAAP for purposes of Medicare reimbursement, Section 233 of the PRM is plainly an interpretative rule. The Secretary's regulations authorize reimbursement of "capi-

tal-related costs" that are "appropriate and helpful in * * * maintaining the operation of patient care facilities." 42 C.F.R. 413.9(b)(2); see generally 42 C.F.R. 413.130-413.157. Such costs include "[n]ecessary and proper interest" and other costs associated with capital indebtedness. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153(a)(1) and (b). The regulations also require that allowable costs be related to beneficiary care. 42 C.F.R. 413.5(a), 413.9; see 42 U.S.C. 1395x(v)(1)(A)(i).

The regulations do not, however, spell out how otherwise allowable bond issuance costs, which are normally amortized over the life of the bonds to which they relate, should be treated when the liability to which they relate is removed from the provider's books by an advance refunding transaction. Nor do they make clear how other costs of such a refunding should be allocated among reporting periods to maintain a proper relationship to the provision of beneficiary care. The Provider Reimbursement Manual exists to provide detailed interpretative guidance in exactly such situations (see 42 C.F.R. 405.1803(b), 405.1829(a), 405.1867), and Section 233 provides the specific answer applicable here. Section 233 "merely * * * elaborate[s] on what is already contained in the regulations," *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1210 (5th Cir. 1980); it neither imposes new substantive obligations nor creates "new law, rights or duties." *General Motors Corp. v. Ruckelshaus*, 742 F.2d at 1565. In the absence of an overriding regulatory requirement of GAAP-based treatment, there is no warrant for the court of appeals' conclusion that PRM § 233 is void as an improperly issued substantive or "legislative" rule.

4. The court of appeals' erroneous interpretation of the complex statutory and regulatory scheme governing the Medicare program warrants review by this Court. As explained above, the courts of appeals are divided on the question whether the Secretary and intermediaries act-

ing on her behalf are required to apply GAAP when adjudicating Medicare reimbursement claims.

Moreover, the issue is of substantial practical importance. The Department of Health and Human Services informs us that there are at least 70 cases (involving 126 providers) pending before the agency or in court that raise the GAAP-requirement issue in the specific context of advance refunding transactions. The agency expects more such cases (and other cases raising the GAAP issue in contexts other than advance refunding) to arise in future years—and, in particular, before completion of the processing of cost reports for the 1990 fiscal year, after which most providers will be reimbursed for capital costs under the prospective payment system (see note 1, *supra*).¹⁴

The Department of Health and Human Services estimates the total amount of refunding losses at issue in pending cases to be approximately \$240 million. In most cases, the amount of the allowable refunding loss is undisputed, and the only issue is whether the loss should be allowed in the year of the refunding transaction or amortized over some longer period. In such cases, the fiscal impact on the Medicare program consists primarily

¹⁴ The issue is of continuing importance despite the ongoing transition to PPS reimbursement of capital-related costs. See note 1, *supra*; compare *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. at 2155 n.3, 2157. First, certain Medicare providers (or some of their facilities) will continue to be reimbursed under the "reasonable cost" system. See 42 C.F.R. 412.22-412.30, 412.300(b). *Good Samaritan*, 113 S. Ct. at 2155 n.3. Second, during the ten-year capital PPS transition period commencing October 1, 1991 (see 42 C.F.R. 412.304), a portion of a provider's reimbursement for capital-related costs under PPS will generally be based on its historic costs during a base year—usually fiscal 1990. If the Secretary were required to recognize advance refunding losses in their entirety in the year of a refunding transaction, a provider that recognized such a loss in what became its base year could receive a substantial windfall, the effects of which would continue throughout the PPS transition period.

of the time value of making payments on an accelerated basis.¹⁵ The Department estimates that the amount thus at issue in all pending cases presenting the GAAP issue in the advance refunding context alone could be up to \$50 million in substantive liability and \$50 million in statutory pre-judgment interest (see 42 U.S.C. 1395oo(f)(2)).

Finally, even aside from its potential monetary impact on the Medicare program, the court of appeals' decision disregards this Court's repeated injunction that an agency's interpretation of its own regulations should be given "controlling weight" unless it is plainly erroneous or inconsistent with the language of the regulation. *E.g.*, *Stinson*, 113 S. Ct. at 1919 (collecting cases). Scrupulous observance of that principle is particularly important in the context of Medicare's complex statutory and regulatory regime. In administering that regime in a changing medical and financial world, the Secretary must rely not only on the general principles of the Medicare statute and regulations, but also on an extensive set of detailed interpretative guidelines such as those set out in the PRM. Moreover, while judicial misinterpretation of the Secretary's regulations could in theory be corrected through further agency action, such action could not be made retroactive to the numerous cases already pending before the

¹⁵ As explained above (see page 21, *supra*), "reasonable cost" reimbursements are determined by apportioning a provider's total allowable costs for a given period between Medicare and non-Medicare patients. See 42 C.F.R. 413.50-413.56. Thus, for example, out of a total advance refunding loss of \$672,581, respondent sought reimbursement of approximately \$314,000, based on its Medicare utilization rate for 1985. The percentage of a provider's allowable costs properly apportionable to Medicare patients may vary substantially from period to period. Thus, spreading recognition of a provider's accounting loss over several years for Medicare purposes will affect not only the time value of the reimbursement, but potentially also the total amount finally apportionable to Medicare patients and reimbursable by the government. See, *e.g.*, App., *infra*, 49a & n.13 (Administrator's decision).

agency or in the courts—or, indeed, to any dispute that might arise over a cost report for any year preceding issuance of a new regulation. See *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

The court of appeals' use of innocuous or, at most, ambiguous statements contained in the first general regulations issued under the Medicare Act to invalidate otherwise valid, specific and sensible interpretative rules, adopted after years of practical experience and set out in the Provider Reimbursement Manual, threatens to disrupt both the administration of the Medicare program and the proper relationship between the Secretary and the courts. Its decision warrants review and reversal by this Court.

CONCLUSION

The petition for a writ of certiorari should be granted.
Respectfully submitted.

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FEBRUARY 1994

APPENDIX A

**UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT**

No. 92-3563

**GUERNSEY MEMORIAL HOSPITAL,
PLAINTIFF-APPELLANT,**

v.

**SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE.**

Argued March 2, 1993

Decided June 18, 1993

**Before: JONES and NELSON, Circuit Judges; and
LIVELY, Senior Circuit Judge.**

DAVID A. NELSON, Circuit Judge.

Appellant Guernsey Memorial Hospital, a participant in the federal government's Medicare program, is entitled to reimbursement by the Department of Health and Human Services for reasonable costs incurred in providing services to Medicare patients. Such costs include the cost of money employed in financing hospital improvements.

(1a)

The particular costs at issue in this case are known technically as "advance refunding" or "defeasance" costs: costs incurred in connection with the refunding of bonded mortgage indebtedness ahead of schedule in order to obtain new financing. It is undisputed that the hospital is entitled to reimbursement for reasonable advance refunding costs. There is a dispute, however, as to when and how reimbursement is to be made—in a lump sum payable now, or in a series of payments stretched over the remaining life of the original bonds?

Under generally accepted accounting principles (referred to in the accounting world as "GAAP"), advance refunding costs are not amortized over the life of the original bonds. Such costs must be recognized, in full, up front. Regulations promulgated by the Department strongly imply, if they do not say in so many words, that reimbursement will be made on the basis indicated by GAAP.

A Department manual on reimbursement provides otherwise. The manual says that any loss incurred through advance refunding of existing debt must be amortized, as opposed to being recognized immediately.

Unlike the regulation, the manual was not adopted in accordance with the notice and comment procedures mandated, for substantive rules, by the rule-making section of the Administrative Procedure Act, 5 U.S.C. § 553. The dispositive question presented here is whether the manual provision constitutes a substantive rule, under the Administrative Procedure Act, or an "interpretative" rule to which the statutory notice and comment requirements do not apply. If substantive, the rule is void; if merely interpretative, it is not. See *State of Ohio Dep't of Human*

Services v. U.S. Dep't of Health & Human Services, 862 F.2d 1228 (6th Cir. 1988).

We conclude that the manual's amortization requirement effects a substantive change in the regulations. It is not an interpretation, it is a stand-alone substantive rule. And it is void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it.

The district court, in the decision now before us on appeal, impliedly held the manual to be interpretive; the court therefore upheld the validity of the amortization requirement. 796 F.Supp. 283. We shall reverse the court's decision on this point. The decision will be affirmed on an unrelated point involving the proper treatment of income earned on funds placed in an account dedicated to the payment of interest on the newly issued bonds.

I.

Guernsey Memorial Hospital, a not-for-profit acute care institution located in Cambridge, Ohio, paid for certain capital improvements with the proceeds of mortgage revenue bonds issued in 1972 and 1982. This bonded indebtedness was refinanced, on advantageous terms, in 1985.

Most of the proceeds of the 1985 bond issue were used to purchase United States Treasury obligations that were escrowed for the benefit of the holders of the older bonds. This advance refunding arrangement permitted defeasance of the mortgages on the hospital property, and the liens of the 1972 and 1982 bond indentures were discharged and released in 1985.

Prior to the 1985 advance refunding the hospital had been amortizing various costs (including legal

and accounting fees, feasibility study costs, and underwriter discounts) incurred in connection with the earlier bond issues. When the earlier bonds were "defeased," the hospital—acting in accordance with GAAP,¹ as required by 42 C.F.R. § 413.20—took the unamortized balance of these costs as a charge against current income. A call premium advanced by the hospital in 1985 as part of the cost of defeasance was handled the same way, also in accordance with the requirements of GAAP.

The advance refunding costs came to a net amount of \$672,581. Of that sum, the hospital sought reimbursement of approximately \$314,000.

The request for reimbursement was denied by the "fiscal intermediary" to which such requests are routed initially. The hospital appealed to the Provider Reimbursement Review Board, a body established by the Secretary of HHS pursuant to 42 U.S.C. § 1395oo. After an evidentiary hearing the Review Board issued a decision allowing reimbursement in full as of 1985. (The Review Board also decided in

¹ GAAP consists of the three official publications of the American Institute of Certified Public Accountants: Accounting Principles Board opinions, Financial Accounting Standards Board statements, and Accounting Research Bulletins. If these publications are silent on a question, the consensus of the accounting profession governs. See *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 n. 3 (9th Cir.1989). The Accounting Principles Board issued APB Opinion 26, titled "Early Extinguishment of Debt," in 1972. The opinion directed that "[a] difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains and identified as a separate item. . . . Gains and losses should not be amortized to future periods." Opinion 26, ¶ 20.

favor of the hospital on a debt service fund issue that will be discussed in Part III of this opinion.) Upon review by the Administrator of the Health Care Financing Administration, however, the decision of the Review Board was reversed. Under 42 C.F.R. § 405.1875 the reversal represented the final decision of the Secretary.

Insofar as reimbursement of advance refunding costs was concerned, the Administrator held, in accordance with a policy announced in § 233 of the agency's Provider Reimbursement Manual, that the items in question had to be amortized over the life of the refunded debt. The Administrator said that the manual section was "interpretive" of the regulations.

Pursuant to § 1878(f) of the Social Security Act, 42 U.S.C. § 1395oo(f), the hospital sought judicial review in the United States District Court for the Southern District of Ohio. In a carefully considered decision published at 796 F.Supp. 283 (S.D. Ohio 1992), that court denied a summary judgment motion of the hospital and granted summary judgment to the Secretary on both the amortization issue and the debt service fund issue. As to the former issue, the district court recognized that manual section 233 "does not have the force of regulation because it was not subject to the notice and comment procedure which precedes adoption of regulations codified in [the Code of Federal Regulations]." *Id.* at 286. The district court nonetheless held that it was permissible for the agency to follow the manual in preference to GAAP. For the reasons stated in the part that follows, we disagree.

II

The amount the Department pays for services provided by hospitals such as Guernsey Memorial is fixed by statute at "the reasonable cost of such services, as determined under section 1395x(v) of [Title 42 of the United States Code]," if that cost does not exceed "the customary charges with respect to such services." 42 U.S.C. § 1395f(b)(1). "The reasonable cost of any services shall be the cost actually incurred," § 1395x(v) provides, "and shall be determined in accordance with regulations establishing the method or methods to be used"

"In prescribing the regulations," § 1395x(v) goes on to say, "the Secretary shall consider, among other things, the principles generally applied by national organizations" We can safely assume that "national organizations" keep their books in accordance with "generally accepted accounting principles."

The fact that the Secretary must "consider" GAAP in prescribing her regulations does not mean that GAAP must be adopted in the regulations, of course. But when one turns to Part 413 of Title 42 of the Code of Federal Regulations—a part devoted in its entirety to "Principles of Reasonable Cost Reimbursement"—one finds what appears to be a flat statement that generally accepted accounting principles "are followed." See 42 C.F.R. § 413.20, which is contained in a subpart dealing with "Accounting Records and Reports."

"The principles of cost reimbursement," § 413.20 (a) says, "require that providers [hospitals, *e.g.*] maintain sufficient financial records and statistical data for proper determination of costs payable [*i.e.*, reimbursable by HHS] under the program." The regulation continues as follows:

"Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will *not* be required in order to determine costs payable under the principles of reimbursement." (Emphasis supplied.)

Where a hospital keeps its books on the accrual basis and in accordance with an approved method of cost-finding, changes not only are not required by the regulations, they do not seem to be permitted: "The cost data *must* be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(a) (emphasis supplied). Section 413.24(b)(2) goes on to give this explanation of the accrual basis of accounting:

"Under the accrual basis of accounting, revenue is reported in the period it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid."

In general terms, the introduction to Part 413 explains, "the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement."

It is undisputed, in the case at bar, that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting and in accordance with generally accepted accounting principles. It is undisputed that the hospital put up money in 1985 or before for all

of the items at issue here, and it is undisputed that these costs were "incurred," under GAAP, in 1985.

Were it not for § 233 of the Provider Reimbursement Manual, any fair-minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred. But § 233, which deals specifically with advance refunding costs, calls for a departure from GAAP in this instance. "When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding," § 233.3 provides, "[u]namortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment" Summing up the effect of this accounting treatment, § 233 explains that "[t]he effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately."

Although this treatment of advance refunding costs is in conflict with GAAP, there is nothing irrational about it. A respectable argument can be made that the treatment required by § 233 of the manual squares with economic reality, and we do not doubt that the Secretary would have the power to promulgate an actual regulation embodying the substance

of § 233. The Secretary's problem, of course, is that she has not done so.

As the district court recognized in this case, the manual "does not have the force of regulation." 796 F.Supp. at 286. Issuance of the manual was not preceded by publication in the Federal Register of a notice of proposed rulemaking pursuant to 5 U.S.C. § 553(b). The public was not given advance notice of the terms or substance of any proposed rule on the treatment of advance refunding costs, or a description of the subjects and issues involved. See 5 U.S.C. § 553(b)(3). And interested persons were given no opportunity to submit written data, views, or arguments for consideration by the Secretary in advance of promulgation. See 5 U.S.C. § 553(c).

If § 233 of the manual were merely an "interpretative" rule, it would be valid without a formal rulemaking proceeding by reason of a statutory exception to the notice and comment requirements. See 5 U.S.C. § 553(b)(A). If the rule is substantive in character, however—if it is "legislative," in other words—the agency's failure to comply with the rulemaking requirements of the Administrative Procedure Act is fatal to its validity. See *State of Ohio Dep't of Human Services v. U.S. Dep't of Health & Human Services*, 862 F.2d 1228, 1233-37 (6th Cir. 1988). A rule that works a substantive change in existing regulations is clearly a legislative rule that must be adopted in accordance with the Administrative Procedure Act.

As one district court has noted, in holding against the Secretary in a case that is squarely in point here,

"Where a [Providers Reimbursement Manual] provision exceeds its purpose and conflicts with

an existing regulation or statute, it is invalid under the APA. See, e.g., *National Medical Enters. [v. Bowen]*, 851 F.2d [291] at 293 [(9th Cir.1988)] (PRM interpretations hostile to accrual accounting regulations will not be enforced since regulation and not PRM has force of law); *Vista Hill Found., Inc. v. Heckler*, 767 F.2d 556, 559-60 (9th Cir.1985) (court will defer to Secretary's interpretations only when consistent with statute and regulations); *Fairfax Nursing Center, Inc. v. Califano*, 590 F.2d 1297, 1301 (4th Cir.1979) (Secretary may not promulgate regulations and then change their meanings by interpretations or clarifications without formal notice or comment.)" *Mercy Hospital v. Sullivan*, Civil No. 90-0024 P, 1991 WL 104090 (D.Me. April 25, 1991).

Like the *Mercy Hospital* court, we believe that § 233 of the Providers Reimbursement Manual impermissibly changes the meaning of validly adopted regulations. Accord: *Baptist Hospital East v. Sullivan*, 767 F.Supp. 139 (W.D.Ky.1991); *Ravenswood Hospital Medical Ctr. v. Schweiker*, 622 F.Supp. 338 (N.D.Ill.1985). Contra: *Mother Frances Hospital of Tyler, Texas v. Shalala*, 818 F.Supp. 990 (E.D. Tex.1993).² The Secretary's argument to the contrary is not persuasive.

² The Court of Appeals for the Ninth Circuit has suggested, by way of dictum, that in the cost reimbursement context the Secretary can depart from GAAP only where the departure is authorized in a regulation. *Villa View Community Hosp., Inc. v. Heckler*, 720 F.2d 1086, 1093 n. 18 (9th Cir.1983). The Fourth Circuit has said that even if there are situations in which the Secretary may create a conflict with GAAP through

What the Secretary says, basically, is that the regulations relied on by the hospital deal only with the manner in which the hospital is to *report* its advance refunding costs. The regulations are silent as to the manner in which these costs are to be *reimbursed*, as we understand the argument; the manual simply clears up something that would otherwise have been ambiguous, according to the Secretary.

But the sentence in 42 C.F.R. § 413.20(a) that says standardized reporting practices "are followed" does not exist in a vacuum. The very first sentence of that section of the regulations begins with a reference to "[t]he principles of *cost reimbursement*." (Emphasis supplied.) The sentence that comes immediately after the sentence prescribing use of standardized reporting practices says that changes in these standardized practices "will not be required in order to determine *costs payable* [by HHS] *under the principles of reimbursement*." (Emphasis supplied.) The whole purpose of Part 413, as the introduction to that part explains, is to "set[] forth regulations governing Medicare payment" for services furnished, on a cost reimbursable basis, by hospitals and similar health care providers. 42 C.F.R. § 413.1(a).

The rule set forth in the manual ignores the structure of the regulations and assumes the existence of a regulatory ambiguity that we have not been able

interpretation of existing regulations, "the Secretary would be at the very limit of [her] authority in doing so." *Charlotte Memorial Hosp. & Med. Center v. Bowen*, 860 F.2d 595, 600 (4th Cir.1988). Interpretations departing from GAAP "would be subject to greater scrutiny than interpretations which are consistent with GAAP," the Fourth Circuit has said. *Id.*

to detect. Insofar as the manual provision may represent an interpretation of the regulations, it is neither reasonable nor persuasive—and such interpretations are not binding on the courts. *Ohio State University v. Secretary of HHS*, 996 F.2d 122, 124 (6th Cir.1993). We find nothing to the contrary in *Good Samaritan Hospital v. Shalala*, — U.S. —, 113 S.Ct. 2151, — L.Ed.2d — (1993), where the Supreme Court deferred to an agency interpretation which, while it was not the sole permissible interpretation of an ambiguous statute, gave “reasonable content to the statute’s textual ambiguities.” *Id.* at —, 113 S.Ct. at 2162, quoting *Department of the Treasury, IRS v. FLRA*, 494 U.S. 922, 933, 110 S.Ct. 1623, 1629, 108 L.Ed.2d 914 (1990).

On July 13, 1992, subsequent to the district court’s issuance of its opinion in the case at bar, the Provider Reimbursement Review Board considered another case concerning timing of Medicare reimbursement for an advance refunding loss. *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Assn.*, Board Dec.No. 90-0543. Over the dissent of one of the five members participating, the Board rejected the view (the view adopted, as the decision notes, by the district court in the instant case) that “42 C.F.R. § 413.20 pertain[s] only to record-keeping requirements and not to reimbursement.” Slip Op. at 15. We find the Board’s reasoning instructive:

“In finding that 42 C.F.R. § 413.20 deals with record-keeping requirements and not reimbursement, the *Guernsey* court apparently concludes that the Medicare program has certain requirements for record-keeping and totally different requirements for reimbursement. The majority

of the Board believes that the court’s analysis fails to take into consideration the nexus between cost reporting and cost reimbursement.

* * * * *

“The majority of the Board believes that the purpose of cost reporting is to enable a hospital’s costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement.

* * * * *

“... 42 C.F.R. § 413.24 requires that cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. Under the accrual basis of accounting, expenses are to be reported in the period in which they are incurred, regardless of when paid. Under the accrual basis of accounting, the loss on defeasance was incurred in the period when the bonds were defeased. The majority of the Board believes that 42 C.F.R. § 413.24 requires that the Secretary determine cost on the accrual basis unless a specific regulation to the contrary has been promulgated.” Slip Op. at 16.

The “nexus” that exists in the regulations between cost reporting and cost reimbursement is too strong, in our view, to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act. Insofar as the decision issued by the district court in this case holds otherwise, the decision is reversed.

III

Guernsey Hospital's 1985 trust indenture created a debt service fund for payment of amounts due on the refunding bonds. Two separate accounts were established within that fund: one for the repayment of principal and one for the payment of interest. Guernsey began to deposit money into these accounts immediately upon the issuance of the 1985 bonds. From February 1 to December 31, 1985, the investment yield on the money in the interest account came to \$24,874. The hospital did not offset this amount against its allowable interest expense. The fiscal intermediary took exception to this, reducing the reimbursement for interest expense in 1985 by about \$12,000.

The Provider Reimbursement Review Board decided this issue in favor of the hospital, holding that no offset was required. Reversing the Board's decision, the Administrator held that an offset was required. Upon review, the district court agreed with the Administrator.

For reasons stated by the district court at 796 F.Supp. 292-93, we affirm the decision of the district court on this issue.

IV

In summary, we REVERSE the district court decision insofar as the issue discussed in Part II hereof is concerned, and we AFFIRM it insofar as the issue discussed in Part III is concerned. The case is REMANDED to the district court for entry of summary judgment in favor of the appellant hospital on the former issue.

APPENDIX B

UNITED STATES DISTRICT COURT
S.D. OHIO, E.D.

No. C2-90-828

GUERNSEY MEMORIAL HOSPITAL, PLAINTIFF

v.

LOUIS W. SULLIVAN, M.D., SECRETARY OF HEALTH
AND HUMAN SERVICES, DEFENDANT

March 30, 1992

MEMORANDUM AND ORDER

HOLSCHUH, Chief Judge.

I.

Guernsey Memorial Hospital, a nonprofit acute care hospital located in Cambridge, Ohio, filed this action seeking review of a final decision of the Healthcare Financing Administration (HCFA) administrator dealing with two cost reimbursement issues arising under Medicare. The parties agree that this court has jurisdiction to review that decision under 42 U.S.C. § 1395oo. The record of administrative proceedings has been filed with the court, and the parties have each moved for summary judgment,

supplementing their respective filings as recently as March 12, 1992, with citations to additional decisions of the Provider Reimbursement Review Board, the HCFA administrator, two other district courts, and the United States Supreme Court. The court's review of the Secretary's decision is not *de novo*, but is limited to determining whether the Secretary's action was unsupported by substantial evidence, or was arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. See 42 U.S.C. § 1395oo(f)(1); *Memorial Hospital/Adair County Health Center v. Bowen*, 829 F.2d 111, 116 (D.C. Cir.1987).

II.

The facts in this case are not in dispute. In 1972, Guernsey Hospital issued \$7,600,000 in bonds to finance capital improvements. In 1982, it issued another \$10,410,000 of bonds for similar purposes. In 1985, in order to take advantage of more favorable interest rates which would, in its view, save it approximately \$12,000,000 in debt service over the life of the two prior bond issues, eliminate certain restrictions on additional borrowing contained in those debt instruments, and free up funds to buy medical equipment, the hospital participated in a new bond issue in the amount of \$15,375,000.

The refinancing arrangement involved, *inter alia*, deeding the hospital to the City of Cambridge and leasing it back. It also required the hospital to deposit \$16,011,200 in an escrow account under the control of BancOhio National Bank as trustee. In exchange for doing so, the hospital was released of any further obligation to the bondholders who purchased hospital bonds in 1972 and 1982. The trustee

would use the money in escrow to "advance purchase" some or all of the old bonds, and was also entitled to use the rent payments made by the hospital to the city for purposes of repaying the new bonds. To that end, a Debt Service Fund, or DSF, was created, divided into two separate accounts, one for the repayment of principal on the bonds, and one for the repayment of interest.

Because this refinancing occurred in 1985, Guernsey Hospital was required, under applicable regulations, to report the impact of the refinancing pursuant to Generally Accepted Accounting Procedures (GAAPs). The parties agree that, under GAAPs, the hospital properly reported a loss of \$672,581 in 1985. Guernsey Hospital sought to include this loss as an operating cost for 1985, and to receive appropriate reimbursement for the loss under the Medicare program.

In Ohio, requests for reimbursement under Medicare are channeled through a fiscal intermediary, which has primary responsibility for determining what costs will be reimbursed. In this case, the fiscal intermediary was Blue Cross and Blue Shield/Community Mutual Insurance Company. That entity determined that, under provisions set forth in the Provider Reimbursement Manual, the loss could not be taken in full in 1985, but rather was required to be amortized over a period of years. Guernsey Hospital appealed that decision to the Provider Reimbursement Review Board, which overruled the fiscal intermediary. The Board, in turn, was reversed by the HCFA administrator, who concluded, like the fiscal intermediary, that the loss would have to be amortized. That issue is the primary one presented for review.

Guernsey Hospital has also asked this court to review a second decision of the administrator which, again, upheld the action of the fiscal intermediary and overruled the Provider Reimbursement Review Board. A certain amount of interest was earned on the interest portion of the Debt Service Fund during 1985. The Secretary offset that interest against other interest expenses incurred by Guernsey Hospital. The hospital contends that the Debt Service Fund, including both the principal account and the interest account, is a "qualified funded depreciation account." If that is so, under applicable regulations, the interest earned in such an account may not be used by the Secretary to offset other interest expenses claimed by the hospital. As with the first issue presented for review, the facts concerning this matter are not in dispute. Rather, it is the Secretary's interpretation of applicable regulations which Guernsey Hospital seeks to have this court overturn.

III.

As with most cases involving actions by the Secretary of Health and Human Services, there are three sources of authority which must be examined. The first is the governing statute; the second consists of the implementing regulations; and the third is the Secretary's interpretation of those regulations. Because the two reimbursement issues in this case are governed by different sets of regulations, the Court will treat each separately. The court will also, prior to analyzing the Secretary's action in this case, enunciate the appropriate standard for review of the Secretary's interpretation of the regulations and statute at issue.

A. *The Bond Refinancing Issue*

1. *Applicable Statutes, Regulations and Interpretations.*

The basic statutory authority for reimbursement of reasonable costs by qualified healthcare providers is 42 U.S.C. § 1395x(v). The statute provides, in pertinent part:

"(1)(A) The reasonable costs of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; . . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment . . . to providers of services on account of services furnished to such recipients by such providers."

Acting under this statutory grant of authority, the Secretary has promulgated regulations relating to reimbursement of Medicare providers. Those regulations now appear at 42 C.F.R. Part 413. The general principles for cost reimbursement are set forth in 42 C.F.R. § 413.5, which provides that "[a]ll necessary and proper expenses of an institution in the production of services . . . are recognized." The par-

ties agree that the refinancing cost incurred by Guernsey Hospital is a cost which is reimbursable under this general principle. As noted above, the disagreement involves the timing of reimbursement. The parties appear to agree that there is no specific regulation which addresses this issue.

The more general regulation dealing with the timing of payments is 42 C.F.R. § 413.20, which is contained in Subpart B of the regulations ("Accounting Records and Reports"). Section 413.20(a) requires that providers "maintain sufficient financial records and statistical data for proper determination of costs payable under the program." It then provides:

"Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries."

Further, 42 C.F.R. § 413.24 requires providers who receive payment on the basis of reimbursable costs to provide adequate cost data based upon verifiable financial and statistical records. That section requires that the accrual method of accounting be followed which, according to § 413.24(b)(2), means that "revenue is reported in the period when it is earned . . . and expenses are reported in the period in which they are incurred. . . ."

These regulations, of course, must be applied by fiscal intermediaries who administer the Medicare program. To assist them in doing so, the Secretary has also published the PRM, which does not have the force of regulation because it was not subject to the notice and comment procedure which precedes adoption of regulations codified in CFR. Section 233 of the PRM, published in May, 1983 and in effect when Guernsey Hospital refinanced its debt, deals specifically with advance refunding. Section 233.3 requires that debt issue costs on the "refunding debt" be amortized over the life of that debt, and that call premiums or penalties of serial bonds must be prorated over the scheduled maturity or recall dates of those bonds. As set forth at the conclusion of that section, "[t]he effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately." (Administrative Record at 991-92).

One further matter is relevant to this issue. The parties also agree that current GAAPs, represented by Opinion No. 26 of the Accounting Principles Board and Statement No. 76 of the Financial Accounting Standards Board, would recognize the entire cost of the refunding debt as an expense in the year incurred. Thus, a very narrow issue is presented for review: is the Secretary required, by the applicable statute and regulations, to treat Guernsey Hospital's 1985 refinancing expense in accordance with generally accepted accounting principles, or may the Secretary, following the PRM, elect a differ-

ent treatment? The court now turns to the appropriate legal analysis of this question.

2. Legal Standard Applicable.

The arguments raised in this case require several levels of analysis. There are three sources of law to which the court must look in deciding which party's interpretation of federal law is correct. The first is the governing statutes; the second is the implementing regulations; and the third is the agency's interpretation of those regulations. A somewhat different set of legal precepts applies to each level of analysis.

First, with respect to the interpretation of the statutes as enacted by Congress, "it is elementary that '[t]he starting point in every case involving construction of a statute is the language itself.'" *Southeastern Community College v. Davis*, 442 U.S. 397, 405, 99 S.Ct. 2361, 2366, 60 L.Ed.2d 980 (1979), quoting *Blue Chip Stamps v. Manor Drug Stores*, 421 U.S. 723, 756, 95 S.Ct. 1917, 1935, 44 L.Ed.2d 539 (1975) (Powell, J., concurring); see also *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. 235, 241, 109 S.Ct. 1026, 1030, 103 L.Ed.2d 290 (1989). If the statutory language is plain, it conclusively establishes the intent of the legislature except in those rare cases where the result of giving the statute its plain meaning is demonstrably different from the clear intent of the drafters of the statute. *United States v. Ron Pair Enterprises, Inc.*, 489 U.S. at 242, 109 S.Ct. at 1031; see also *United States v. Underhill*, 813 F.2d 105, 111 (6th Cir.), cert. denied sub nom. *Rayburn v. United States*, 482 U.S. 906, 107 S.Ct. 2484, 96 L.Ed.2d 376 (1987).

Strict adherence to the rule that a statute is to be given its plain meaning has significant desirable con-

sequences. First, it discourages judicial legislating, thereby keeping the legislative power vested in the appropriate and popularly-elected branch of government. It also encourages the drafters of legislation to speak plainly and precisely, knowing that if they do so, the courts will enforce the law as it has been clearly articulated. Finally, it promotes certainty in the law, eliminating the need for resort to other interpretive devices such as a review of legislative history, which is usually a grab-bag from which support for almost any interpretation of a statute can readily be plucked. There are cases, however, where Congress has not clearly expressed in the language of a statute what result was intended. "Where the literal language of the statute does not conclusively reveal legislative intent, the courts must look beyond literal meaning, analyzing the provision in context with the whole." *In re Arnett*, 731 F.2d 358, 361 (6th Cir.1984). Where the context of an entire statute does not reveal the meaning of a particular provision, resort to extrinsic aids to demonstrate Congressional intent, such as legislative history, can be an appropriate way to determine legislative intent, or at least to support a particular reading of a statute where the intent of the drafters is sufficiently obscure that it can never be divined with certainty.

The above rules of statutory construction apply in all cases, but the court must be mindful of some additional rules when interpreting a statute which has previously been construed, through the process of enacting regulations, by the agency charged with the duty to enforce the statute. It has been held that "[w]hen the issue is the validity of a regulation issued under a statute that agency is charged with administering, it is well established that the agency's

construction of the statute is entitled to great weight." *Melamine Chemicals, Inc. v. United States*, 732 F.2d 924, 928 (Fed.Cir.1984). Nevertheless, the Court must be mindful of its own duty to interpret the statute according to its plain meaning. "Although an agency's interpretation of the statute under which it operates is entitled to some deference, 'this deference is constrained by our obligation to honor the clear meaning of the statute, as revealed by its language, purpose, and history.'" *Southeastern Community College v. Davis*, 442 U.S. 397, 411, 99 S.Ct. 2361, 2369, 60 L.Ed.2d 980 (1979), quoting *Teamsters v. Daniel*, 439 U.S. 551, 556 n. 20, 99 S.Ct. 790, 800 n. 20, 58 L.Ed.2d 808 (1979). Consequently, although in an appropriate case the party attacking an agency's interpretation of a statute through the issuance of a regulation bears a heavy burden of persuasion, the Court "will not abdicate to federal agencies the interpretation of regulations which are promulgated pursuant to an empowering statute. . . . Any regulation promulgated pursuant to rule making authority conferred by statute assumes the force of law only to the extent that it is consistent with the statutory scheme it was designed to implement." *Mitchell v. White Motor Credit Corp.*, 627 F.Supp. 1241, 1249 (M.D.Tenn.1986).

In this case, the Court must deal not only with the intent of Congress in passing the statute involved, and with the reasonableness of the Secretary's interpretation of that statute through the adoption of regulations, but also the issue of interpreting the meaning of those regulations in light of the Secretary's own construction of them. It is also well-established that an administrative agency's interpretation of its own regulations is entitled to substantial deference.

Chevron USA, Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed. 2d 694 (1984); *Bradley v. Austin*, 841 F.2d 1288 (6th Cir. 1988). Again, however, the Court is constrained to reject an agency's interpretation of a regulation if the interpretation is clearly at odds with the language of the regulation itself—that is, an interpretation is acceptable only if it "does no violence to the plain meaning of the [regulatory] provision." *University of Cincinnati v. Bowen*, 875 F.2d 1207, 1209 (6th Cir.1989), quoting *Deukmejian v. Nuclear Regulatory Commission*, 751 F.2d 1287, 1310-11 (D.C.Cir.1984); see also *Fluor Constructors v. Occupational Safety and Health Review Commission*, 861 F.2d 936, 939 (6th Cir.1988).

It is with these guiding principles in mind that the Court now turns to the precise legal issues presented by the 1985 refinancing.

3. Analysis.

It is helpful to set forth, briefly, the details of each party's position and the support which each has marshalled. The court begins with the Hospital's position, which is, in essence, the position taken by the PRRB in several different matters presenting essentially the same facts, and which has been adopted by judicial decisions from the Western District of Kentucky and the District of Maine. Relying primarily upon the rationale of decisions such as *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir.1988), the Hospital claims that the Medicare Act requires both that reasonable costs of Medicare providers be reimbursed, and that the Secretary promulgate regulations after considering accounting practices which are generally followed in the industry.

Building upon that statutory mandate, the Secretary's regulations (primarily 42 C.F.R. §§ 413.20 and 413.24) provide that, unless there is some other regulation to the contrary, the Secretary shall reimburse costs based upon the accrual method of accounting and in accordance with generally accepted accounting principles. There is no promulgated regulation which provides for a different treatment of costs incurred in refinancing. Consequently, any effort by the Secretary, through the PRM or otherwise, to treat the refinancing costs other than in accordance with GAAPs is "contrary to the law" in the sense that it contradicts the regulations which have been promulgated. The keystone to this argument is, of course, the claim that "where the specific regulation is silent on the subject [of the particular costs involved], as it is here, the regulation establishing general principles for cost reporting must be deemed applicable," and that the regulation requires the Secretary to follow GAAPs. *National Medical Enterprises v. Bowen*, 851 F.2d 291, 294 (9th Cir.1988).

The Secretary agrees that the Medicare Act requires both reimbursement of reasonable costs and consideration of GAAPs. The Secretary further agrees that the accrual method of accounting should ordinarily be followed, and that hospitals are required to *report* their costs in accordance with GAAPs. However, the Secretary views 42 C.F.R. § 413.20 as a reporting requirement, and not as a mandate that costs be reimbursed in the same fashion as they are required to be reported. Rather, the Secretary's position is that if any other permissible purpose served by Medicare reimbursement, such as prevention of cross-subsidization or recharacterization of accounting charges to make them more reflective of

the economic reality of delivery of services to patients, is served, the Secretary can choose to depart from GAAPs so long as that departure is not arbitrary. The Secretary's position is perhaps best stated by the following quotation from *American Medical International, Inc. v. Secretary of HEW*, 466 F.Supp. 605, 623 (D.D.C.1979); "this provision [42 C.F.R. § 413.20] only provides that accepted accounting practices be used in uniform record-keeping, not in determining costs allowable under the Medicare Act," *aff'd*, 677 F.2d 118 (D.C.Cir.1981). Because the regulation does not, in the Secretary's view, mandate slavish adherence to GAAPs, and because the Secretary has a reasonable basis for concluding that the "loss" experienced by Guernsey Hospital in 1985 relates to future benefits—i.e., the reduction in interest payments over the course of many years—the Secretary did not act arbitrarily in determining, in accordance with the PRM, that the cost must be amortized. The Secretary stresses that amortizing this cost does not violate principles of accrual accounting, and the issue here is not whether the accrual method is being followed, but whether the Secretary is free to follow the minority view of the FASB and require that the 1985 loss be amortized.

The two district courts which have considered this precise issue have both adopted Guernsey Hospital's position. The more detailed of the two decisions is Magistrate Judge Cohen's opinion in *Mercy Hospital v. Sullivan*, No. 90-0024 P, 1991 WL 104090 (D.Me. April 25, 1991) *aff'd* *Mercy Hospital v. Sullivan*, No. 90-0024 P (September 13, 1991) (Carter, Chief Judge). *Mercy Hospital* dealt with a slightly different situation, in that the PRM sections in effect at that time allowed the Secretary to treat a loss on re-

financing by amortizing it over years, but also allowed the Secretary to treat a gain on refinancing by recognizing it entirely in the year in which the gain is recognized under GAAP. Otherwise, the facts are the same.

Mercy Hospital first rejected the Secretary's argument that to recognize the full loss in one year would violate the statutory prohibition against cross-subsidization, primarily because there was no evidence in that case that the hospital did not properly allocate the expense, even if it was claimed all in one year, as between Medicare and non-Medicare patients. The same is true in this case. The *Mercy Hospital* court further concluded that other regulations, including particularly 42 C.F.R. § 413.5, should be taken into account. That regulation requires payment to be made on the basis of current costs, and should not disadvantage providers by requiring them to pay out money well before reimbursement is received. Consequently, the court's conclusion was that the regulations, taken as a whole, did not require the Secretary to amortize the cost of refinancing over a period of years, and that to recognize it in one year would not violate any particular regulation.

That, of course, does not answer the precise question posed, which is whether the Secretary may reasonably amortize the cost even though he is not required to do so. In *Mercy Hospital*, the court read the applicable sections of the PRM as dealing only with the reasonableness of refinancing costs and not the timing of reimbursement. Assuming, however, that § 233 was a clarification of the Secretary's position and supported amortization of the costs, the Court concluded, relying upon *Charlotte Memorial Hospital, supra*, that such an approach was "contrary

to the applicable regulations and impermissible under the [Administrative Procedure Act]." In conclusion, *Mercy Hospital* held that the Secretary had explicitly promulgated regulations generally applying GAAPs, and that the Secretary could depart from such principles only by promulgating other regulations "providing for another method of accounting and reimbursement."

Mercy Hospital rejected the Secretary's argument that § 413.20 relates only to the record-keeping practices of the hospitals, relying upon the reasoning in *St. Luke's Hospital v. Secretary of Health and Human Services*, 632 F.Supp. 1387, 1391 (D.Mass. 1986), *vacated on other grounds*, 810 F.2d 325 (1st Cir.1987), to the effect that a separation between record-keeping requirements and reimbursement procedures is "illogical." That court's interpretation of § 413.20 was that presenting financial records in accordance with GAAPs was mandated precisely because the Secretary fully intended to reimburse institutions under the same procedures, and that to suggest that the Secretary retained discretion to do otherwise is "contrary to the structure of the regulations." *Mercy Hospital*, slip op. at 21. Recognizing *Mercy Hospital* as the strongest decision in support of the Hospital's position, the question becomes whether this court is persuaded by its rationale, or whether there are any significant points in the analysis at which this court and *Mercy Hospital* part company. The court concludes, for the following reasons, that *Mercy Hospital* is not persuasive precedent, and that the Secretary's decision in this case must be upheld because it is a permissible interpretation of the applicable statute and regulations.

Mercy Hospital and other cases which have limited the Secretary to the use of GAAPs in the absence of a specific regulation to the contrary all rely on the Ninth Circuit's decision in *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (1983). That case, however, did not hold that the Secretary was required to rely on GAAPs, because the Secretary did not depart from those principles in that case. The court merely noted in a footnote that the Secretary normally reimbursed costs based upon GAAPs. In the same footnote, the court noted that the Secretary had, by notice published in the Federal Register, specifically reserved the right to reimburse costs differently based upon actual patient care costs if GAAPs did not produce a satisfactory result. *Villa View Community Hospital*, 720 F.2d at 1093 n. 18. The Secretary correctly points out that cases decided after *Villa View*, such as *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir.1988), *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir.1989), and *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir.1988), all cite to *Villa View* as standing for the principle that the Secretary must, in the absence of regulations to the contrary, apply GAAPs.

Guernsey Hospital argues that, whether *Villa View* stands for the proposition it is often cited for or not, the plethora of cases after *Villa View* which have accepted Guernsey Hospital's position suggests that the position has now become law. Of course, these cases are persuasive only to the extent that their reasoning strikes this court as fundamentally sound. The soundness of their reasoning depends, in turn, on whether they have properly construed the statute

and regulations as prohibiting the Secretary from taking the opposite view which, in turn, means that the Secretary's interpretation of the regulations must be manifestly unreasonable. The court does not believe that it is.

The central focus of this analysis is 42 C.F.R. § 413.20. The decisions above have relied heavily upon the apparently mandatory provision that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed." (Emphasis supplied). The title of that section, however, is "Financial Data and Reports," and it appears in Subpart B of the regulations which is entitled "Accounting Records and Reports." The first sentence of Section 413.20(a) clearly refers to the requirement that "providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program." The balance of § 413.20 deals with the frequency with which providers are to supply cost reports, record-keeping requirements for new providers, and continuing provider record-keeping requirements. Subsection (e) permits program payments to be suspended if a provider does not maintain adequate records. None of the provisions in § 413.20, however, is either titled in a way that suggests it deals with cost reimbursement principles, or deals specifically with cost reimbursement. General rules of cost reimbursement are set forth in Subpart A of the regulations, and particularly in § 413.5, which lists six general objectives of cost reimbursement. None of the those objectives makes any specific reference to GAAPs, and § 413.5 (b)(4) points out that there should be "sufficient flexibility in the methods of reimbursement to be

used. . . ." Given the structure of these regulations, the requirement in the statute that the Secretary "consider," but not necessarily follow without deviation, generally accepted accounting principles, and the deference given to the Secretary's interpretation of these regulations, this court cannot say that the Secretary's conclusion that GAAPs need not be followed in all cases is an impermissible interpretation.

The conclusion that the Secretary is not inescapably bound by GAAPs does not, however, mean that every decision to depart from those principles is reasonable. In order for the Secretary's decision to be immune from reversal on grounds that it is arbitrary or capricious, the Secretary must have a permissible rationale for choosing to use some method other than GAAPs to determine when a particular allowable cost is reimbursable. See, *Charlotte Hospital*, *supra*, which concluded that the specific departure from GAAPs in that case was unreasonable. It is the court's view that the Secretary has a rational basis for concluding that this particular loss should be amortized over the life of the pre-existing debt, and that his departure from GAAPs cannot be considered arbitrary or capricious.

ABP No. 26 was apparently developed as a result of accountants' concerns that similar types of transactions be given similar treatment. For example, if pre-existing debt is cancelled in a particular year by recalling the debt, any costs associated with that transaction are recognized in the year of the recall. In a case such as this, where the debt is not immediately recalled but provisions are made for its repayment in the future, the transaction is treated in the same way. The Secretary concluded, however, that this approach focuses on the immediate reduc-

tion in the net worth of the provider from the transaction, but does not focus upon the fact that the benefits of the transaction are spread out over a number of years. The Secretary has chosen to characterize a transaction such as this one as "an adjustment to the Provider's capital structure" (Tr. 7), but, in terms of its effect on patient care services, the Secretary concluded that "[t]he loss is more closely related to the years over which the original bond term extended. . . ." *Id.* This is also the minority view expressed by the three dissenting members of the Board which adopted ABP No. 26.

The fact that an argument can be made for amortizing this particular loss, and that there was some disagreement even among those accountants who promulgated GAAPs, convinces the court that the Secretary did not act in an arbitrary or capricious manner in choosing to follow the minority viewpoint. The Secretary also argues, of course, that to recognize the entire loss in the year of refinancing would violate the "cross-subsidization" principles of the Medicare Act. That argument was considered and rejected in the *Mercy Hospital* decision, and the court need not consider it here. It is enough to say that the Secretary has a rational basis for concluding that, by amortizing this particular cost, he has more closely approximated the impact of the transaction upon the provider's cost of patient care. If the evidence of record suggested that rational accountants could not disagree on this point, and that the only possible way of treating this cost was to recognize it in full in the year in which it was incurred, the Secretary's decision might be said to be arbitrary. That is not this case, and the court is not free to substitute

its view for that of the Secretary when the Secretary has not acted irrationally. For these reasons, the court concludes that the Secretary's decision as to the first issue, the timing of the recognition of the loss incurred as a result of the 1985 refinancing, must be affirmed.

B. *The Debt Service Fund Issue*

The nature of this issue is relatively straightforward. Obviously, Guernsey Hospital is required to make repayments both of principal and interest on the new bonds. Two separate accounts have been set up to accumulate funds for such repayment. One is to be used exclusively for accumulation of money to repay capital, and the other is to be used to accumulate money to repay interest.

Under regulations now found at 42 C.F.R. § 413.134(e), the Secretary strongly recommends funding of depreciation. As an incentive, § 413.134(e)(1) provides that "investment income on funded depreciation is not treated as a reduction of allowable interest expense." § 413.134(e)(2)(i) states that the Secretary considers funded depreciation available "for use in the acquisition or replacement of depreciable assets related to patient care" or "for other capital purposes related to patient care." Section 413.134(e)(3) defines proper and improper withdrawals from funded depreciation, distinguishing between proper withdrawals, which are made for the acquisition or replacement of depreciable assets or for other capital purposes related to patient care, and improper requirements, which are all other withdrawals. If an improper withdrawal is made, regulations require that appropriate adjustments be made

in any previously-permitted exemption of the earnings from reducing allowable interest expense.

In this case, the Secretary treated the principal account as a funded depreciation account, since it was being used to repay the principal of obligations which were used to purchase depreciable assets relating to patient care. The Secretary concluded, however, that the interest account was not entitled to similar treatment, because it was simply being used to pay interest on that capital obligation. Guernsey Hospital contends that the interest on the obligation is being accumulated and paid "for other capital purposes relating to patient care" because it is so closely associated with the debt itself. The PRRB apparently adopted this argument, relying on a previous board decision concluding that a single debt service fund which was used to pay both interest and principal met the requirements of a funded depreciation account. Seeing no practical difference between a single fund and separate accounts, the Board concluded that the earned interest should not be used as an offset against otherwise allowable interest expense. The administrator, relying on the language of the regulations and a decision in *Good Samaritan Hospital v. Blue Cross Association/Mutual Hospital Insurance, Inc.*, PRRB Decision No. 79-D80 (November 26, 1979), *aff'd* HCFA Admin. Decision (January 23, 1980), reversed. The parties' arguments in this court are the same as those advanced below.

Again, the court must determine whether the Secretary's decision to refuse to recognize the interest account as a funded depreciation account is arbitrary, capricious, or otherwise not in accordance with law. The applicable regulations, of course, ap-

pear to allow for some flexibility, permitting an account to be so regarded when it is used either for the accumulation of funds to purchase depreciable assets related to patient care or for "other capital-related purposes" so related. The Secretary concluded that repayment of the principal amount of borrowing which was used to purchase depreciable assets was a "capital-related purpose." The question becomes whether interest on that same obligation is necessarily a "capital-related purpose" or whether the Secretary could, without running afoul of the regulations, properly characterize it as something else.

Again, this is an area where the Secretary's decision, in order to be reversed by this court, must possess an element of arbitrariness. It appears that reasonable minds could differ as to whether the interest being repaid was strictly for a "capital-related purpose" or whether it was simply an ordinary interest expense on borrowed funds. The only decision in the record which appears to relate to this issue is the *Good Samaritan* decision cited above. In that case, a "Lease Reserve Account" which accumulated money to be used to repay borrowing was treated as a funded depreciation account, although there existed the possibility that some of the money would be used to pay interest on that borrowing. The Secretary concluded that the existence of that possibility, alone, did not disqualify the interest earned on the fund from favorable treatment, but also stated that if a withdrawal from the fund was used for an improper purpose, such as the payment of interest, a retroactive adjustment would be required.

Good Samaritan is consistent with the position taken by the Secretary in this case. There, because it was unclear whether the money in the Lease Re-

serve Account which had been established would be used to pay interest or principal, the Secretary chose to wait until withdrawals were made and to make appropriate adjustments at that time depending upon the purpose for which the funds were used. Here, by contrast, the interest account was established for the sole purpose of paying interest on the refunding bonds. Guernsey Hospital has not suggested that the funds could properly be used for any other purpose. Under those circumstances, the Secretary need not wait until withdrawals are made in order to identify the purpose of the money, and then make a retroactive readjustment. Rather, he can determine now that the funds will be used only to pay interest. The court is not convinced that the Secretary acted arbitrarily or in violation of any applicable regulation by refusing to consider this interest-only account as sufficiently related to a capital expenditure for patient care purposes as to mandate that it receive the same favorable treatment which is offered as an incentive to hospitals to fund depreciation on capital assets. That being so, the Secretary's decision on this issue will be affirmed as well.

IV.

Based upon the foregoing, the motion of plaintiff, Guernsey Memorial Hospital, for summary judgment, is DENIED. The motion of the defendant, Louis W. Sullivan, M.D., Secretary of Health and Human Services, is GRANTED. The Clerk is directed to enter judgment in favor of the defendant.

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APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

No. 92-3563

GUERNSEY MEMORIAL HOSPITAL,
PLAINTIFF-APPELLANT

v.

SECRETARY OF HEALTH AND HUMAN SERVICES,
DEFENDANT-APPELLEE

ORDER

[Filed Oct. 04, 1993]

BEFORE: JONES and NELSON, Circuit Judges;
and LIVELY, Senior Circuit Judge.

The court having received a petition for rehearing en banc, and the petition having been circulated not only to the original panel members but also to all other active judges of this court, and no judge of this court having requested a vote on the suggestion for rehearing en banc, the petition for rehearing has been referred to the original hearing panel.

The panel has further reviewed the petition for rehearing and concludes that the issues raised in the

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petition were fully considered upon the original submission and decision of the case. Accordingly, the petition is denied.

ENTERED BY ORDER OF THE COURT

/s/ Leonard Green
LEONARD GREEN
Clerk

APPENDIX D

Health Care Financing Administration

Decision of the Administrator

IN THE CASE OF:

GUERNSEY HOSPITAL
PROVIDER

vs.

BLUE CROSS AND BLUE SHIELD ASSOCIATION/
COMMUNITY MUTUAL INSURANCE COMPANY
INTERMEDIARYClaim for: Provider Cost Reimbursement
Determination of Reasonable Costs for Cost
Reporting Period(s) Ending

December 31, 1985

Review of:

PRRB Decision No. 90-D50

Dated: August 16, 1990

This case is before the Administrator, Health Care Financing Administration (HCFA), for review of the decision entered by the Provider Reimbursement Review Board (PRRB). The review is during the 60-day period in § 1878(f)(1) of the Social Security Act, as amended [42 USC 1395oo(f)]. The Inter-

mediary submitted comments requesting reversal of both issues in the PRRB's decision. On August 31, the parties were notified of the Administrator's intention to review the PRRB's decision. The Bureau of Policy Development (BPD) submitted comments requesting reversal of the PRRB's decision. The Provider submitted comments requesting affirmation. Accordingly, the case is now before the Administrator for final administrative decision.

THE ISSUES AND PRRB'S DECISION

Issue No. 1

Issue No. 1 concerns whether Medicare reimbursement for a loss on defeasance, i.e. the advance refunding of bonds, should be governed by generally accepted accounting principles (GAAP), or by HCFA policy, as expressed in the Provider Reimbursement Manual (HIM-15). The PRRB held that GAAP applied and the loss was allowable in the fiscal period in which the refinancing occurred. In finding the loss allowable, the PRRB noted that it met the criteria for an allowable cost under 42 CFR 405.451.¹

The PRRB also relied upon GAAP, as enunciated in Accounting Principles Board (APB) Opinion No. 26, which it found to conform to the documentation requirements in 42 CFR 405.406 and 405.453.² The PRRB noted that when the Medicare program does not specify the treatment of the costs arising from a transaction, it is required to use GAAP. Further, the loss on defeasance resulted from the change in

¹ Recodified at 42 CFR 413.9.

² Recodified at 42 CFR 413.20 and 413.24, respectively.

the market value of the Provider's debt; therefore, the loss is more appropriately related to prior periods than future periods.

Issue No. 2

Issue No. 2 concerns whether a debt service fund (DSF) required by a bond issue to pay interest expense on the bonds should be treated as a funded depreciation account. The PRRB held that the debt service fund established to repay the interest expense on the refunded bonds qualifies as a funded depreciation account. Therefore, the investment income earned in the account need not be offset against allowable interest expense.

SUMMARY OF COMMENTS

Issue No. 1

The Intermediary urged reversal stating that it properly applied the provisions of § 233 of the Manual. Amortization of the loss over future periods is required as it relates to the care of Medicare beneficiaries over a period of years; not just to the period of the refunding. The Intermediary noted the similarity of the facts in this case to those in *Shawnee Mission*, PRRB Decision No. 83-D54, *Mercy Hospital*, PRRB Decision No. 89-D64 and *Baptist Hospital*, PRRB Decision No. 89-D65, in which the Administrator required amortization.

The Provider, requesting affirmation, noted that the PRRB's decision responded to the Administrator's arguments in *Mercy* and *Baptist*. The Provider also cited *Ravenswood Hospital Medical Center v. Schwei-*

ker, 662 F. Supp. 338 (N.D. Ill. 1985), as a persuasive authority in a similar factual context.

The BPD requested reversal stating that § 233 of the Manual was properly applied in this case. This section would amortize a loss incurred on the advance refunding of debt over the future periods to which it relates. The loss incurred on the advance refunding relates to the patient care services provided over the term of the debt, not just to the year in which the refinancing occurred. BPD also noted that it structured the provisions of § 233 in accordance with industry consultation.

Issue No. 2

Both the Intermediary and BPD requested reversal, stating that under § 226 of the Manual, and prior Administrator's decisions, the payment of interest expense is not a proper use of funded depreciation. To the extent funds are used for this purpose, offset is required. The Provider requested affirmation noting that prior PRRB decisions support this current decision.

DISCUSSION AND EVALUATION

The entire record which was furnished by the Provider Reimbursement Review Board has been examined, including the transcript of the oral testimony before the PRRB, all correspondence, position papers, exhibits, and the parties' post-hearing briefs. The PRRB's decision has been reviewed by the Administrator. All comments received after entry of the PRRB's decision have been made a part of the record and have been considered.

Issue No. 1

The underlying facts of this case are not in dispute. The Provider borrowed approximately \$7.6 million in 1972, and \$10.4 million in 1982, through the issuance of bonds, to finance various capital projects. The interest rate on the bonds varied at approximately 5.25 to 7% on the 1972 bonds and 12 to 12.5% on the 1982 bonds. On February 1, 1985, the Provider refinanced the bonds with a new issuance at rates varying from 6.5 to 10.5%. All of the funds were then turned over to a trustee who became responsible for payment of the refunded debt. As a result of this transaction, the Provider expects to save approximately \$12 million in interest expense over the remaining term of the 1985 bonds.

The Provider calculated a loss of \$672,581 on the refunding of the 1972 and 1982 bonds in accordance with APB Opinion No. 26, "Early Extinguishment of Debt." The Provider has claimed the entire loss in its cost reporting period ending December 31, 1985. The loss is attributable to unamortized bond issue and discount costs on the refunded bonds, the difference between investment income earned by the trustee and interest expense on the refunded bonds, and a call premium on the 1982 bonds.

Under § 1814(b) of the Social Security Act [42 USC 1395f(b)], providers of health care services to Medicare beneficiaries are entitled to be reimbursed for the "reasonable cost" of the capital-related component of providing such services.³ "Reasonable cost" is de-

³ The loss claimed by the Provider in this case is a capital-related cost, which is reimbursed in the same manner under the Prospective Payment System, which became effective in 1984, as it was under the cost-based system.

financed in the Social Security Act as "the cost actually incurred . . . and . . . determined in accordance with the regulations."⁴ Those regulations must "consider, among other things, the principles generally applied by national organizations or established prepayment organizations, (which have developed such principles) in computing the amount of payment." One overriding requirement of the legislation and related regulations is that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the cost with respect to individuals not so covered will not be borne by such insurance programs."⁵

When the Medicare regulations do not specifically address the method of calculating a particular cost, GAAP will usually provide a reasonably accurate calculation of the cost of delivering health services to a provider's patients. GAAP consists of the official publications of the American Institute of Certified Public Accountants (AICPA). These official publications consist of Accounting Principles Board (APB) opinions, Financial Accounting Standards Board (FASB) statements, and Accounting Research bulletins (ARB). Where there is no official pronouncement, the consensus of the accounting profession, as manifested in textbooks, determines GAAP.⁶

While GAAP can be useful in determining costs related to patient care, they are not necessarily con-

⁴ § 1861(v)(1)(A) of the Act [42 USC 1395x].

⁵ *Id.*

⁶ *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181, n.3 (9th Cir. 1989).

trolling. § 1861(v)(1)(A) of the Act only required the Secretary to "consider . . . the principles generally applied by national organizations;" the Secretary is not required to adopt them for determining reimbursable cost.⁷ Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy.

When evaluating whether it is appropriate to use GAAP for calculating Medicare reimbursement, one must first consider whether Medicare has a specific policy in effect. If Medicare does not, one must determine whether GAAP will identify costs that are in economic reality borne by the provider, and if so, whether the cost is properly related in time to care being rendered to Medicare beneficiaries.⁸

The Administrator finds that for the Provider's fiscal year under review, Medicare did have a specific policy in effect governing the treatment of refunding transactions. That policy, found in § 233 of the Provider Reimbursement Manual, is consistent with the preferred method under ARB No. 43. § 233 was published in May 1983, and was effective for all cost

⁷ *Spartanburg General Hospital v. Heckler*, 607 F. Supp. 635, 641 (D.S.C. 1985). Cf. *Sun Towers, Inc. v. Heckler*, 725 F.2d 314, 328-9 (5th Cir. 1984); *American Medical International, Inc. v. Secretary*, 466 F.Supp. 605, 624 n.21 (D.D.C. 1979), aff'd, 677 F.2d 118 (D.C. Cir. 1981).

⁸ *Humana, Inc. v. Heckler*, 758 F.2d 696, 705, n.68 (D.C. Cir. 1985). See also, *Doctors Hospital v. Califano*, 459 F. Supp. 201, 208-210 (D.D.C. 1978), affirming a PRRB decision disallowing a "loss" on the demolition of two buildings despite a regulation apparently allowing the loss, because the "economic realities of the transaction" were to increase the value of the underlying land more than the remaining value in the buildings.

reporting periods beginning on or after July 1, 1983. The refinancing at issue here occurred February 1, 1985.

The effect of § 233 is to require the loss on a refunding to be amortized over a number of years. This section is interpretive of 42 CFR 405.451, "Cost Related to Patient Care"⁹ which requires payments to be based on "the actual cost of services rendered to beneficiaries during the year." This policy more accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries than does APB No. 26.

§ 233 superseded § 215 of the Manual, and expressly applied to advance refunding of debt. It requires any gain or loss on the transaction to be amortized from the date of the refunding transaction to when the refunded bond principal is paid. This section was a clarification rather than a change of policy.¹⁰

The economic realities of the case at hand demonstrate the superiority of amortizing the loss on defeasance, rather than allowing the full cost in the year of refinancing. While the Provider's obligation on the original bond issue to repay principal of approximately \$15.6 million increased slightly with the refinancing, the overall interest obligation over the remaining term of the borrowing would decrease substantially. Since Medicare would recognize interest, which is the cost incurred for the use of borrowed funds,¹¹ as an allowable cost in the years when ac-

⁹ Recodified at 42 CFR 413.9.

¹⁰ § 233.1, PRM Transmittal No. 288, May 1983.

¹¹ 42 CFR 413.153.

crued, this would represent a substantial saving to both the Provider and the program. This savings would be spread over the years from 1985, when the refinancing occurred, until 2003, when the refunding bonds would be paid. The Provider estimated the net present saving to be approximately \$12 million.

Medicare does not reimburse principal as such. The repayment of principal is not a cost; it is merely using an asset (cash) to cancel a liability of equal value. Medicare does, however, reimburse providers for Medicare's share of the cost of a capital asset, related to patient care, which was purchased with borrowed money. For example, Medicare will recognize as an allowable cost depreciation on a building constructed with borrowed money.¹² In this way, the principal amount is reimbursed.

Although the Provider improved its financial outlook, APB No. 26 advised it to recognize a loss on the refunding, because the APB limited its concern to the treatment of the principal obligation. This may be prudent for financial reporting, because the Provider's net worth was immediately reduced because of the increased principal obligation, but the full reduction of the interest obligation will not be enjoyed until future periods.

However, this loss is not a cost of providing health care services to Medicare beneficiaries in the year of the refunding. The loss was merely an adjustment to the Provider's capital structure which enabled the Provider to substitute less expensive financing for its existing more expensive financing. Thus, the loss on

¹² 42 CFR 413.134.

the refinancing did not relate exclusively to patient care services rendered in the year of the loss. The loss is more closely related to the years over which the original bond term extended (the period over which the lower interest will be enjoyed) than to the year in which the refunding occurred.

The Administrator notes that this loss is reported on the provider's financial statements as an extraordinary item, separate and apart from the "Operating Expenses." The loss is related to patient services expected to be rendered over the unexpired term of the defeased bond issuance, when the lower interest rates are being enjoyed. This is further evidence that the loss is not a current period cost.

Accordingly, the Administrator finds that the loss is a cost of rendering patient care over several years. By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases.¹³ Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years.

¹³ Similarly, the court in *Spartanburg General Hospital v. Heckler*, 607 F.Supp. 635, 646 (D.S.C. 1985), held: "Capitalization [of certain planning costs] will result in the costs being reimbursed both at the time Medicare patients actually use the building and commensurate with the changing levels of Medicare utilization over the years. The court defers to the Secretary's policy choice, cognizant of her responsibilities as the steward of a public trust."

The statutory prohibition against cross-subsidization¹⁴ requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during those years when Medicare beneficiaries use those services. The U.S. Court of Appeals for the Eighth Circuit used similar reasoning in *Research Medical Center v. Schweiker*, upholding the Secretary's requirement that construction interest be capitalized. The Court wrote:

"The capitalization requirement of Sec. 206 of the Provider Reimbursement Manual attempts to implement the statutory requirement that Medicare costs should not be borne by non-Medicare patients. Capitalization allows the Medicare reimbursement to change as the percentage of Medicare patients in a medical facility changes over the years. . . . If the interest expense were currently reimbursed, and [the provider] withdrew from the Medicare program shortly after the construction was completed, [the provider's] non-Medicare patients would benefit for many years from a Medicare reimbursement."¹⁵

Likewise, in *Gosman v. United States*,¹⁶ the Court of Claims declined to use GAAP in favor of a Provider Reimbursement Manual section which required the cost of securing mortgage financing to be amortized and reimbursed over the life of the mortgage.

¹⁴ Note 4, *supra*.

¹⁵ 684 F.2d 599, 603 (8th Cir. 1982).

¹⁶ 573 F.2d 31, *supra* note 8.

The Administrator notes that the Provider was not required by the refinancing to make any immediate out-of-pocket payment to satisfy the refinancing loss. Instead, the loss was absorbed by the greater amount borrowed under the 1985 series of bonds. Thus, the Provider has not actually experienced an immediate unreimbursed outflow of funds. Reimbursement of the loss over a period of years, therefore, will more accurately allocate the Provider's refinancing costs, and at the same time, more accurately reflect its current period costs.

Accordingly, the Administrator hereby holds that § 233 of the Manual is applicable to the Provider's bond refunding transaction. The effect is to amortize the loss on the advance refunding over those periods which benefit from the reduced interest rate.

Issue No. 2

The facts in this issue are also clear and undisputed. As part of its 1985 bond refinancing, the Provider was required to establish two debt service accounts with the trustee: one for payment of principal on the refunding bonds, and the other for the payment of interest. The Provider contributed to these accounts with funds from operations. The trustee then disbursed the funds as required.

Under 42 CFR 413.153(a)(1), necessary and proper interest expense is an allowable Medicare cost. In defining "necessary," 42 CFR 413.153(b)(2)(iii), requires that interest be reduced by investment income except when it is from funded depreciation or a qualified pension fund. Funding depreciation is authorized under 42 CFR 413.134(e) and § 226 of

the Manual, and is the setting aside of funds for the acquisition of depreciable assets or other capital expenditures related to patient care. In describing other capital purposes, § 226 states "Other capital purposes include capital debt liquidation, such as *principal* payments for bonds and mortgages and nonborrowed bond reserve and sinking funds to the extent used for a capital purpose . . ." [emph. added]

In this case, there were two bond reserve accounts: one for payment of principal and the other for payment of interest. There is no dispute that the account for payment of principal qualifies as a funded depreciation account and no offset is required. However, the funds set aside for payment of interest do not qualify as funded depreciation because they are not being used for a capital purpose. Interest is not a capital cost; it is a current period operating expense. It is apparent from § 226 of the Manual, that Medicare does not recognize interest as a capital cost, and, therefore, funds set aside to pay interest do not qualify as funded depreciation.

The Administrator notes that the *Good Samaritan*¹⁷ case, referenced by the Provider, does allow a bond fund that will pay interest to be recognized as a funded depreciation account. However, in that case the reserve fund was established to pay both principal and interest, without any distinction of funds within the account. In the current case, two separate funds were created for the separate paying of prin-

¹⁷ *Good Samaritan Hospital v. Blue Cross Association/Mutual Hospital Insurance, Inc.*, PRRB Decision No. 79-D80 (Nov. 26, 1979), *aff'd* HCFA Admin. Decision (Jan. 23, 1980).

cipal and interest, respectively. Further, the Administrator stated in *Good Samaritan* that in the event the funds set aside to pay interest could be identified, those amounts would not qualify as funded depreciation and offset would be required. Accordingly, the investment income earned in the debt service fund must reduce allowable interest expense.

DECISION

The decision of the Provider Reimbursement Review Board is reversed on both issues. The Provider must amortize the loss on the early refunding of the 1972 and 1982 bond issuances in accordance with § 233 of the Provider Reimbursement Manual (HIM-15). Also, the Provider must offset investment income earned in the debt service fund designated to pay interest against allowable interest expense.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10-12-90

/s/ J. Michael Hudson
J. MICHAEL HUDSON
Deputy Administrator
Health Care Financing Administration

APPENDIX E

*Provider Reimbursement Review Board
Hearing Decision*

90-D50

Date of Hearing—August 22, 1989

PROVIDER—GUERNSEY MEMORIAL HOSPITAL
CAMBRIDGE, OHIO
Provider No. 36-0203

vs

INTERMEDIARY—BLUE CROSS AND BLUE SHIELD
ASSOCIATION/COMMUNITY MUTUAL INSURANCE
COMPANY

Cost Reporting Period Ended—December 31, 1985

Case No. 88-1092

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ISSUES:

1. Whether the Intermediary's adjustment disallowing a portion of the Provider's loss on the advance refunding of debt is correct?
2. Whether the Intermediary's adjustment offsetting a portion of the income earned by the Debt Service Fund because the Fund was deemed as not used for capital purposes is correct?

SUMMARY OF FACTS:

The Provider is a general, short-term, acute care hospital located in Cambridge Ohio. The Intermediary issued a Notices of Program Reimbursement (NPR) on November 30, 1987, for calendar year 1985 which included audit adjustments relating to the above issues. The Provider filed a request for hearing with the Provider Reimbursement Review Board (Board) pursuant to 42 CFR 405.1835ff and has met the jurisdictional requirements of those regulations. Both issues result in a reduction in Medicare reimbursement of approximately \$326,000.

Issue No. 1—Loss on Bond Advance Refunding

Prior to February 1, 1985, the Provider was obligated to pay debt service costs on bonds issued in 1972 and 1982 to fund certain hospital improvements which were related to patient care. The original principal amounts of these bonds were \$7,600,000 and \$10,410,000 in 1972 and 1982, respectively. The 1972 bonds had interest rates ranging from 5.25% to 7% and were scheduled to be paid off by December 1, 1986. The 1982 bonds had interest rates rang-

ing from 12% to 12.5% and were scheduled to paid off in 2012. The 1982 bonds also had an option for recall (call date) of 1992.

The Provider decided to advance refund both of those bonds issues by issuing \$15,375,000 Hospital Improvement Revenue Refunding Bonds, Series 1985 (refunding bonds). On February 1, 1985, the City of Cambridge Ohio (the City) and the BancOhio National Bank (Trustee) executed a trust indenture issuing the 1985 refunding bonds on behalf of the Provider. These bonds had interest rates ranged from 6.5% to 10.5% with approximately two-thirds of the 1985 refunding bonds carrying the 10.5% rate. In turn, the Provider deeded its hospital facilities to the City which then leased the same back to the Provider. The proceeds of the 1985 refunding bonds together with the remaining sums in various restricted funds created by the earlier bond issuances amounted to \$16,011,200. Those funds were deposited into an irrevocable escrow account maintained by the Trustee. The Trustee was responsible for paying the interest and principal on the refunded 1972 and 1982 bonds. On February 27, 1985, the City, Trustee, and the Provider executed a release whereby the Provider was discharged from any further obligations regarding the refunded bonds.

As a result of this advance refunding the Provider incurred and claimed on its cost report an extraordinary loss of \$672,581 calculated as follows:

NET REACQUISITION PRICE:

Purchase of escrow securities	\$16,011,200
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NET CARRYING AMOUNT OF OLD DEBT:

Old debt:

1982 Bonds outstanding	\$10,410,000
1972 Bonds outstanding	5,220,000
Unamortized financing cost	(709,499)
Interest expense payable	418,118

NET CARRYING AMOUNT OF OLD DEBT	\$15,338,619
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LOSS ON ADVANCE REFUNDING OF DEBT	\$ 672,581
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The Intermediary disallowed the entire loss claimed by the Provider which resulted in a reduction in Medicare reimbursement of approximately \$314,000.

Provider's Contentions:

The Provider contends that various Medicare regulations support the recognition of the loss on the advanced refunding of the 1972 and 1982 bonds. 42 CFR 405.402(a) requires that payments for costs be made on a current basis. 42 CFR 405.452(a) requires that reimbursement be made on accrual accounting principles, and that expenses be reported in the period in which they are incurred regardless of when they are paid. The Intermediary's recognition and amortization of the loss over the life of the refinancing bonds conflicts with the latter regulation. 42 CFR 405.406(a) which requires standardized definitions, accounting, statistics and reporting practices which are widely accepted in the hospital and related fields has been met. The Provider used Generally Accepted Accounting Principles (GAAP) to arrive at this loss. Specifically, it used Accounting

Principle Board (APB) No. 26 and Financial Accounting Standard (FAS) No. 76.

The Provider compiled with the reasonable cost requirements of 42 CFR 405.451. By advance refunding the 1972 and 1982 bonds, the Provider has demonstrated that it would save approximately \$12 million in debt service costs due to the lower interest rate and shorter life of the 1985 refunding bonds. The issuance of the 1985 refunding bonds also eliminated several restrictive covenants present in the 1972 and 1982 bond indentures. That allowed the Provider the ability to incur additional debt at a lower interest rate and released capital to purchase additional patient care facilities (TR 36, 37).

Provider Reimbursement Manual (PRM) section 233 which the Intermediary used to disallow the loss on the advance refunding of the 1972 and 1982 bonds is contrary to the above regulations as well as GAAP and case precedent. Both parties have stipulated that the Intermediary's treatment of the Provider's loss did not comply with GAAP (Provider Exhibit 35). Moreover, the PRM section is illogical. It is forcing a loss recognition into the future for something that had happened previously which the Provider cannot reverse in the future (TR 160, 161). The Intermediary's application of PRM section 233.3 is not based on actual costs. Its combining the debt service costs of the refunded and refunding bonds and offsetting them by the investment income earned by the Trustee's escrow account does not properly measure the Provider's costs. Further, the Intermediary's witness testified that the interest expenses on the refunded bonds was a cost of the Trustee and not the Provider's cost (TR 198, 199). PRM section 233.3 is in-

ternally inconsistent. The Intermediary admitted that had the Provider sought to call the refunded bonds in 1985, which would have been more costly than placing the proceeds of the refunding bonds in escrow, the Intermediary would have allowed the refinancing loss in full in 1985.

GAAP should be used in this case and is supported by case law. In *Ravenswood Hospital Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill 1987), the District Court supported the Board's decision that the Provider was entitled to take the full loss on early debt extinguishment in the year incurred. GAAP supports this treatment. In *Charlotte Memorial Hospital and Medicare Center, Inc. v. Bowen*, U.S. Ct. of Appeals, Fourth Cir., No. 87-3745 (September 1988), the Circuit Court rejected both a PRM section and an Intermediary Letter because they both conflicted with GAAP. Because of that conflict, the Court found that the Medicare Program's instructions cut against the very tenor of 42 CFR 405.453. In *Hollywood Presbyterian Hospital—Olmstead Memorial v. Bowen*, CV 87-2595 (C.D. Cal. September 2, 1988), the District Court struck down a PRM section which was inconsistent with GAAP. In *National Medical Enterprise v. Bowen*, U.S. Ct. of Appeals, Ninth Circuit, No. 87-5605 (July 1988), the Circuit Court pointed out that a regulation has the force of law; therefore, an agency's interpretation of a statute in a manner inconsistent with the regulation will not be enforced. Based on these decisions, GAAP, and not PRM section 233, should be applied to this situation. Moreover, Board decision 89-D65, dated September 26, 1989, *Baptist Hospitals Group*, controls this case. The facts are essentially the same as the Provider's.

Intermediary Contentions:

The Intermediary contends that various Medicare regulations prohibit the Provider from claiming the loss on the advance refunding of its 1972 and 1982 bonds. 42 CFR 405.451 is the primary regulation that supports its position. The loss is not a reasonable cost related to patient care in 1985, the year of the advance refunding. A loss is not a cost. In this case, the loss results from the substitution of one debt for another. For a cost to be allowed, paying cash or incurring a liability in exchange for goods or services that enhance patient care must occur. This loss does not meet that reasonable cost requirement. Moreover, when the individual elements of the loss are identified, they do not meet the reasonable cost requirements in 1985. The elements of the loss consist of: (1) unamortized bond issue and discount costs on the refunded bonds; (2) the call premium on the 1982 bonds; and (3) the difference between the investment income earned by the trustee and the interest expense on the refunded bonds. None of those elements related to patient care in 1985.

The accrual accounting requirement of 42 CFR 405.453 is not violated by the Intermediary's rejection of the Provider's total loss in 1985. The key term in this regulation is *expense*. The Provider is arguing that since it chose APB No. 26's current income statement recognition of a loss over a deferred recognition, this turns the loss into an expense. The Intermediary disagrees. Further, 42 CFR 405.419 does not allow as interest expense an amount needed to fund a trustee required escrow account larger than the 1972 and 1982 bonds balance and unamortized finance costs.

PRM section 233 should be applied in this case. The objective of that section i.e., to recognize any gain or loss incurred as a result of an advance refunding from the date the refunding debt is issued to the date the bondholders receive the refunding debt principal rather than an immediate loss recognition, is consistent with 42 CFR 405.451. This treatment of the loss is consistent with the nature of the financing transaction, i.e., to pay for the debt over some specified future period. That matches Medicare utilization with the payment of the refunding debt. It protects the Medicare program by not making payments for future periods in a current cost reporting period. It protects Medicare from paying excessive amounts currently because providers may terminate from the Medicare program or have significantly reduced Medicare utilization in future years when the refunding bonds are being paid-off. Further, although PRM section 233 treats the loss on the advance refunding differently than GAAP, it is only one of several PRM sections that do so. The reason for this is that GAAP is concerned with providing a consistent reporting of a financial position for investors and management. On the other hand, the Medical program instructions are concerned with determining reasonable costs of providing services to Medicare beneficiaries.

Various subsections of PRM 233 properly treat the various elements of the refunding bonds. PRM section 233.3 would allow the call premium, if exercised, in 1992. That is the year it would be paid. At the time of the refinancing, unamortized discounts and debt issue costs remained. PRM section 233.3(c) properly amortizes bond issuance costs over the period

from the issue date of the refinancing bonds to the date the bondholders will receive the principal amount. PRM section 233.3(d) allows interest when paid or accrued by either the Provider or Trustee on an annual basis.

When APB No. 26 was issued, there was a clear disagreement on how losses on advance refunding should be treated. As noted in discussion point 5. in APB No. 26:

"5. Differences on non-refunding extinguishments are generally treated currently in income as losses or gains. Three basic methods are generally accepted to account for the differences on refunding transactions:

- a. Amortization over the remaining original life of the extinguished issue
- b. Amortization over the life of the new issue
- c. Recognition currently in income as a loss or gain."

Each method has been supported in court decisions, in rulings of regulatory agencies, and in accounting literature.

PRM Section 233 comes closest to using approach a. above. However, instead of using the original life of the bond issue that was refinanced, PRM Section 233 uses the expected pay-off of the refunded bonds as the end of the period of amortization. This makes sense since the identification of the most financially advantageous point to have the Trustee pay off the old debt is an integral part of structuring the refinancing and determining the exact amount that is

needed to effect the refinancing. Therefore, the considerations in support of option a. would be valid in analyzing PRM Section 233 and in determining which option best complies with the reimbursement requirement expressed in Regulation 42 CFR 405.419.

Various Court and Board decisions support the Intermediary's position, refute the Provider's position, or are not relative to this case. The *Methodist Hospital of Indiana, Inc. v. U.S. Inc. v. Heckler*, 725 F.2d 314, and *Sun Towers American Medical International v. Secretary of H.E.W.* 466 F. Supp. 605 support the Intermediary's position on the role of accrual accounting in determining reasonable costs. In the *Ravenswood Hospital Medical Center v. Schweiker* [sic], USDC, Northern District of Illinois, No. 82C4872, May 8, 1985, the Court ruled that a refinancing loss was fully allowable. However, the major element of that cost was a call premium, and it was paid. In this case the call premium cannot be paid until 1992. Also, in the latter decision, the court was concerned with the different treatment of gains as compared to losses. PRM section 233 treats gains and losses similarly. In *Charlotte Memorial Hospital and Mechanical Center, Inc. v. Bowen*, U.S. Court of Appeals, 4th Cir. No. 87-3745 (September 1988), the decision cited by the Provider, the Circuit Court dealt with a totally different factual issue, i.e., deferred compensation. Further, it did not rule out the Medicare program's overruling GAAP. In this case, the Intermediary requests the Board to address the court's challenge of scrutinizing the type of cost at issue. A loss of an advance refunding should result in a departure from GAAP because GAAP does not accurately reflect the cost of patient care. GAAP

recognizes the cost of running a business. Moreover, the advance refunding only results in a modest cost outlay change. Interest and bond issue amortization on the "old" bonds was \$1,472,241. Interest on the "new" bonds was \$1,471,717. Nevertheless, the Provider wants to be reimbursed on the basis of \$2,144,298 of debt. The only "out-of-pocket" expenses incurred by the Provider were the costs of the bond issuances, and those were on the 1972 and 1982 bonds.

Board decision 89-D65, dated September 26, 1989, *Baptist Hospitals Group*, has not been reviewed by the Health Care Financing Administration (HCFA) Administrator. On the other hand, the Board decision 83-D54, dated April 29, 1983, *Shawnee Mission Medical Center* has been, and it clearly focuses on the true nature of the loss from an advance refunding. The latter is a better reasoned case.

The Provider contends that reimbursement for advance refunding losses should be treated the same as a disposal of a capital asset. There are major conceptual differences between these two concepts such as:

OUTRIGHT SALE OF FIXED ASSET

1. Asset removed from books.
2. Removal of asset alone.

LOSS ON REFINANCING

1. Liability removed from books.
2. Removal of liability alone yields a gain. The loss occurs because you replace it with a different liability. There is no loss if you do not borrow more money—this is the sole reason for the loss. The loss doesn't occur because you dispose of a liability.

3. Recognizing the loss in the current year just lets you recover the entire expenditure you made now that the asset is gone.
3. The asset is not gone. It has just cost you more now that you have increased borrowing. This should appropriately be spread over a period of years.
4. The loss resulted because no purchase would pay the owner net book value. (A negative event).

Issue No. 2—Investment Income Offset

As part of the above refunding bond transaction, Article 5 of the Trust Indenture establishes a debt service fund (DSF) for the payment of principal and interest due on the refunding bonds. Pursuant to the provisions of that article, the Trustee, besides controlling the escrow account which was created by the sale of the refunding bonds and will be used to pay off the refunded bonds, maintains custody of the DSF on the refunding bonds. It made periodic deposits into the DSF and was also permitted to make certain investments of sums into same. Any income earned by the DSF was credited to the fund unless there is a need to meet minimum balance requirements of other special funds created by the Trust Indenture. The lease component of the Official Statement relating to the Original Issuance of \$15,375,000 City of Cambridge Ohio Hospital Improvement Revenue Refunding Bonds, Series 1985 (Page 27 of Intermediary Exhibit A) required that a separate interest payment account and principal payment account of the DSF be established. The funds in the interest payment account were used to pay semi-annual interest payable on the 1985 bonds.

Between February 1 and December 31, 1985, the interest account of the DSF earned \$24,874. The Pro-

vider did not offset that interest income earned against its allowable interest expense. The Intermediary did, and this resulted in a reduction in Medicare reimbursement of approximately \$12,000.

Provider's Contentions:

The Provider contends that various Medicare regulations support its position that it was unnecessary to offset investment income against allowable interest expenses when the investment income was earned by a funded depreciation account established for a capital purpose. 42 CFR 405.419(c)(3) requires that if funded depreciation is used for purposes other than improvements, replacement or expansion of facilities or equipment, an offset of investment income earned must be made. The Provider's witness stated in his affidavit that:

1. The DSF serves a capital-related purpose.
2. The payment of principal and interest due on the refunding bonds from sums in the DSF is a capital-related cost of the Provider.
3. The DSF is an integral component of the Provider's 1985 advance refunding of capital indebtedness. In fact, the issuance of the refunding bonds probably would have been impossible without the creation of the DSF.
4. The DSF constitutes a qualified funded depreciation account under Medicare laws and interpretations.
5. Any investment income earned on the DSF should not be offset against the Provider's allowable interest expense.

42 CFR 405.415(e) encourages providers to fund depreciation. The Provider's establishment of the various reserve funds, including the interest and principal fund, responds to this regulatory encouragement.

Board decision 83-D89, dated June 8, 1983, *Medical Center Hospital*, held that investment income earned on a bond restricted sinking fund used for the payment of principal and interest is not properly offset against a provider's allowable interest expense. This was affirmed by the HCFA Deputy Administrator's July 28, 1983 decision. In this case, the DSF has a capital related purpose and, as such, constitutes funded depreciation.

The fact that one portion of the fund may be used to pay principal and the other interest does not change the resulting purpose.

Intermediary Contentions:

The Intermediary contends that 42 CFR 405.419(b)(2) and PRM 226 requires an investment income offset in this case. The interest payment account does not qualify as funded depreciation under the above Medicare regulation and program instruction because the purpose for which the fund was established, i.e., payment of interest expense, is not a valid capital-related purpose. It is an operating expense. Interest expense can qualify as capital-related and be reimbursed on a cost basis under Medicare's Prospective Payment System (PPS). However, the capital-related purpose of PPS is not the same as "capital purposes" stated in PRM section 226.

In its position paper, the Provider referred to Board decision 83-D89, dated June 8, 1989, *Medical Center Hospital*, as it relates to this issue. That decision

references Board decision 83-D46, date June 15, 1984, *Medical Center Hospital*, which in turn references Board decision 79-D31, dated May 31, 1979, *Humana Inc. Group Appeal*. The last decision held:

"The Board finds that evidence clearly demonstrates that the Renewal and Replacement Funds, Bond Security Funds and Reserve Funds in reality are funded depreciation and meet the requirements as set forth in section 226 (HIM-15). On the other hand, with respect to interest accounts maintained under the Colonial Manor Hospital Bond Issue and the Shoals Hospital Bond Issue, and the Insurance Fund maintained under the Medical Center Hospital Bond Issue, the Board finds these are not funds that are restricted for capital purposes; therefore, should not be treated as funded depreciation."

The Provider's analysis of that case actually supports the Intermediary's adjustment.

CITATION OF APPLICABLE LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. *Law—Title XVIII of the Social Security Act:*
 - 1861(v)(1)(A) — Reasonable Cost
2. *Regulations—42 CFR 405, Subpart D:*
 - a. Section 405.406 — Financial Data and Reports
(Redesignated Section 413.20)
 - b. Section 405.451 — Cost Related to Patient Care
(Redesignated Section 413.9)
 - c. Section 405.453 — Adequate Cost Data and Cost Finding
(Redesignated Section 413.24)
 - d. Section 405.419(b)(2) — Necessary
(Redesignated Section 413.153(b)(2))
3. *Program Instructions Provider Reimbursement Manual (HCFA Pub. 15-1):*
 - Section 226 — Funded Depreciation

FINDINGS AND CONCLUSIONS:

Issue No. 1—Loss on Bond Advance Refunding

The Board, after considering the facts, the parties' position papers, evidence presented the testimony at the hearing, and post-hearing briefs, finds that the Provider is entitled to take the full loss on the advance refunding of the Series 1982 bonds in FY 85. The Board finds that the loss on defeasance is an allowable cost under 42 CFR 405.451 and is to be reimbursed in its entirety in the fiscal year at issue. Under GAAP, the loss on defeasance was a cost incurred in FY 85. This accounting treatment conforms with the requirements found in: (1) 42 CFR 405.406—providers are to follow standardized accounting practices; and (2) 42 CFR 405.453—providers are to furnish adequate cost data based on the accrual method of accounting.

Section 405.451 of Volume 42 of the Code of Federal Regulations requires that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services. As provided by 42 CFR 405.451, necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities and are usually costs which are common and accepted occurrences in the field of the providers' activity. The Board holds that the Providers has submitted substantial evidence that the loss on defeasance meets these criteria, i.e., that it was reasonable, related to patient care, a necessary and proper cost, and a common and accepted occurrence in bond financing in the hospital industry.

The crux of the Intermediary's argument was that because there is nothing in the Medicare regulations that identifies a loss on extinguishment of debt as an allowable cost, the Intermediary must first analyze the "loss" against 42 CFR 405.451 to determine if it is allowable. PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component. The Intermediary broke the loss into the following components: call premium, unamortized discount, unamortized issue, and interest expenses. The Intermediary further argued that the Provider's use of GAAP would turn a claimed cost—which it determined to be non-allowable because it does not fall under any of the general or specific categories of allowable cost—into a reimbursable cost just because it may be permissible under GAAP to reflect the item in a provider's financial statements. In other words, Medicare reimbursed providers for specific cost items, not anything that appears as a debit entry on a provider's income statement.

The Board rejects these Intermediary arguments and stresses that it is not turning an unallowable cost into a reimbursable cost solely because it is permissible under GAAP to reflect the loss in the Provider's financial statement. The Board emphasizes that it accepts the Provider's treatment because it believes that the cost, as incurred, is allowable under 42 CFR 405.451—the cost was reasonable, necessary and proper, and related to patient care.

In this case there was no allegation by the Intermediary that the refinancing was not prudent. Therefore, the cost was reasonable as required by 42 CFR

405.451(b)(1). In addition, the refinancing costs were appropriate and helpful in maintaining the operation of patient care facilities and activities. Once the Provider decided that the refinancing decision was prudent, they had very little flexibility regarding the methodology of refinancing. The methodology and attendance costs are common and accepted occurrences in the field of the Providers' activity. Hence, the refinancing costs were necessary and proper costs as defined in 42 CFR 405.451(b)(2).

The loss was related to patient care in 1985, the year of defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically as losses or gains. There would have been no loss on the extinguishment of the debt. For that reason, the entire loss or defeasance should be recorded when the bond contract is terminated, because it relates to the past periods when the bond contract was in effect.

Stated differently, if, when the bonds were issued, it had been known that they would be defeased in 1985, the annual cost associated with those bonds, i.e., interest and bond discount and call premium amortization, would have been adjusted so that the maturity value of the debt would equal the reacquisition price. Thus, no difference upon early extinguishment would have occurred because previous periods would have borne the proper interest expense. This rationale is also supported by GAAP, as outlined in Accounting Prin-

ciples Board Opinion No. 26 on early extinguishment of debt.

This treatment is similar to that which occurs when a fixed asset is disposed of and replaced before the end of its estimated useful life. Any loss on disposal is clearly related to the old asset and not the replacement. The loss results from the fact that the actual depreciation in value of the asset differs from that recorded on the books. For that reason, the loss on disposal is treated as an allowable cost in the year of disposal. Likewise, the loss on defeasance should be treated as an allowable cost in the year of defeasance.

The PRRB recognizes that the Administrator has reversed the Board on this same issue in two prior cases. These are *Baptist Hospitals Group v. Blue Cross and Blue Shield Association/Blue Cross and Blue Shield of Kentucky, Inc.*, HCFA Administrator Decision, Nov. 22, 1989, CCH Medicare and Medicaid Guide (hereinafter CCH), para. 38,308; and *Mercy Hospital v. Blue Cross and Blue Shield*, HCFA Administrator Decision, Nov. 22, 1989, CCH para. 38,307.

In both cases the Administrator discussed the Supreme Court's analysis of the role of GAAP in the income tax system in *Thor Power Tool Company v. Commissioner of Internal Revenue* 439 U.S. 522 (1979) and expressed the opinion that the analysis was applicable to the Medicare cost system. The aspect of *Thor* relied upon by the Administrator was the Court's discussion of the differences in the primary goal of financial accounting and that of the income tax system, and the Court's opinion that, given the diversity of objectives, any presumption of equiva-

lency between tax and financial accounting would be unacceptable.

Essentially, however, the Court's discussion of the differing goals—policy objectives as it were—between the two systems of accounting is but the last leg of the Court's decision that the Commissioner was correct in his decision that the taxpayers write-down of "excess" inventory failed to reflect income clearly even though the write-down conformed to generally accepted accounting principles. The general policy discussion was preceded by a detailed analysis of the governing regulations. In these regulations the Supreme Court found clear authority for the Commissioner to reject any method of accounting unless in the opinion of the Commissioner it clearly reflected income.

One of the governing regulations in *Thor* had provided that "[a] method of accounting which reflects the consistent application of generally accepted accounting principles . . . will ordinarily be regarded as clearly reflecting income." Emphasis added. This same regulation also provided that "no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income." Emphasis added. Yet another governing regulation provided that an inventory taken in conformity with best accounting practice "can, as a general rule, be regarded as clearly reflecting . . . income." Emphasis added. The Plaintiff argued that these regulations created a presumption that accounting for inventory in accordance with generally accepted accounting principles was valid for income tax purposes. The Plaintiff then argued that as long as the taxpayer used generally accepted accounting principles, the burden shifted to the Commissioner to demonstrate that taxpayers

method did not reflect income clearly. The Court rejected this position and stated in part:

We believe . . . that no such presumption is present. Its existence is insupportable in light of the statute, the Court's past decisions, and the differing objectives of tax and financial accounting.

First, as has been stated above, the Code and Regulations establish two distinct tests to which an inventory must conform. The Code and Regulations, moreover, leave little doubt as to which test is paramount. While Section 471 of the Code requires only that an accounting practice conform "as nearly as may be" to best accounting practice, Section 1.446-1(a)(2) of the Regulations states categorically that "*no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income*" (emphasis added). Most importantly, the Code and Regulations give the *Commissioner broad discretion to set aside the taxpayer's method if, "in [his] opinion," it does not reflect income clearly*. This language is completely at odds with the notion of a "presumption" in the taxpayer's favor. The Regulations embody no presumption; they say merely that, in most cases, generally accepted accounting practices will pass muster for tax purposes. And in most cases they will. *But if the Commissioner, in the exercise of his discretion, determines that they do not, he may prescribe a different practice without having to rebut any presumption running against the Treasury.* *Thor* 439 U.S. at 785. Emphasis added.

In contrast to the tax code, the Medicare regulations, principally 42 CFR 405.406, do not appear to provide authority for the Administrator to reject the use of GAAP to determine actual cost. Section 405.406 provides that:

The principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. *Standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.* Essentially the methods of determining costs payable under title XVIII involve making use of data available from the institution's basis accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries. Emphasis added.

In addition 42 CFR 405.453 provides that "The cost data submitted *must* be based on the accrual basis of accounting which is recognized as the *most accurate basis for determining costs.*" Emphasis added.

In short, these regulations provide that:

- widely accepted accounting practices are followed;
- no changes in these practices will be required in order to determine cost; and
- the accrual basis of accounting is the most accurate basis for determining cost.

This language is much stronger than that in *Thor* which, as indicated above, merely provided in part that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. Moreover, the Medicare regulations in question do not appear to provide the kind of authority for the Administrator to reject the use of GAAP to determine actual cost that the Supreme Court found in *Thor*. In fact, they appear to go beyond *Thor* in providing not merely a presumption but an actual requirement that determination of costs conform to generally accepted accounting principles. Indeed, the Board believes that these regulations taken together go far beyond requiring GAAP for mere recordkeeping but appear rather to state unequivocally that *cost* shall be determined according to GAAP.

In emphasizing the Supreme Court's analysis of the *role* of GAAP in the income tax system and applying that to Medicare cost reimbursement, the Administrator in effect omitted an analysis of the actual content and wording of the Medicare regulations—an analysis which the Supreme Court had performed in *Thor*. The only law relied on by the Administrator—in addition to the manual provisions at issue—is that part of Section 1861(v)(1)(A) of the Social Security Act which prohibits cross-subsidization.

Essentially, the principle of cross-subsidization assumes that the “cost” of a service has already been determined and merely prohibits allocating or attributing that cost to the wrong subset of patients. The same statute that prohibited cross-subsidization provided that the reasonable cost of any service was the cost actually incurred excluding unnecessary costs. The statute also said that in prescribing regulations

on payment, the Secretary had to consider among other factors the principles generally applied by national organizations in computing the amount of payment. This statute was implemented through many regulations, but the chief ones of concern to this decision are 42 CFR 405.451, 42 CFR 405.406 and 42 CFR 405.453.

While 42 CFR 405.406 and 42 CFR 405.453 appear to address the process of determining actual cost, 42 CFR 405.451 is a substantive limitation on the reimbursement of actual cost. It provides that all payments to providers of services must be based on the reasonable cost of services and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs. These regulations, at least on their face, would appear to indicate that the actual cost of an item or service would be determined under 42 CFR 405.406 and 405.453 while the allowability of the cost would be determined under 42 CFR 405.451. The Administrator, however, does not address this distinction directly. He states, “The statutory prohibition against cross-subsidization requires that costs recognized in one year, but attributable to health services rendered over a number of years, be amortized and reimbursed during these years when Medicare beneficiaries use these services.” He then uses the issue addressed in *Research Medical Center v. Schweiker*, U.S. Court of Appeals, Eighth Circuit, No. 81-2364, Aug. 9, 1982, CCH para. 32,107 to illustrate this interpretation of cross-subsidization and quotes the Court in that case to the effect that “The capitalization requirement of Sec. 206 of the Provider Reimbursement Manual attempts to implement the statutory requirement that Medicare costs should not be borne by non-Medicare

patients." *Baptist Hospital Group*, CCH para. 38,308 at p. 21,690.

What the Administrator is in effect doing is saying that 42 CFR 405.451, pertaining to costs related to the care of beneficiaries and cross-subsidization, encompasses both a substantive element (i.e., is the item an operating table or a television set?) and a timing element (i.e., to what year does the service apply?). We do not agree with this analysis. Timing must be determined in the context of 42 CFR 405.406, i.e., standardized methods of accounting for those costs and 42 CFR 405.453, i.e., expenses are reported in the period in which they are incurred, regardless of when they are paid. Any other interpretation would conflict directly with the plain language of 42 CFR 405.406. In his decision, the Administrator does not address this issue directly.

The problem of the role of GAAP, however, is not always perceived as just an accounting or timing problem. For instance, in the *Florida Patient Compensation Fund* cases (PRRB Case Nos. 89-D32 and 89-D33), the Board majority believed that there was a substantive problem under 42 CFR 405.451 and that a FASB statement could not make allowable a cost, (assessments for incurred but not reported claims (IBNR)), which was not a necessary cost under 42 CFR 405.451—one for which no statutory obligation had as yet arisen. In addition, longstanding manual provisions provided for reimbursement of actuarially unsound self-insurance on a paid claims basis. Thus, in addition to a lack of a statutory basis for collecting IBNR assessments, the majority also looked to the fact that the statutory scheme was to levy and collect on the basis of known claims, with

the state totally lacking the authority to collect otherwise. The majority concluded that under these circumstances the reimbursement treatment should be similar to that of the manual provisions for unsoundly funded self-insurance—on the reimbursement of claims. The dissent believed that FASB 5, which provided for the accrual for contingent liabilities, should apply. The point is not to reargue *Florida* here but to distinguish *Florida* from the case in contention here—which is a conflict between the application of GAAP and a position derived from policy considerations borrowed from *Thor*, a questionable interpretation of cross-subsidization, and some notion of economic reality chosen by the Intermediary and the Administrator.

Indeed, economic reality is the third principle relied on by the Administrator. The Administrator argues that economic realities demonstrate the superiority of amortizing the loss on defeasance rather than allowing the full cost in the year of refinancing as set forth in APB No. 26. The problem with this approach is that while beguiling (who would want to be caught espousing economic unreality?!) it is not a principle embodied in any regulation nor is it required by statute. The governing statute did not say that actual cost would reflect economic reality, and nowhere does the Secretary define economic reality; not in regulation, manual provision, intermediary letter, or any other policy publication.

Further, HCFA has consistently rejected the concept of economic reality argued by providers in cases regarding recapture of depreciation. In both the old and amended versions of the regulation providing for recapture of depreciation, HCFA has adopted a pol-

icy treatment which exactly coincides with that of GAAP. The Administrator rejected the economic reality of reimbursable wear and tear on depreciable assets. The Administrator also rejected the fact that, as an economic reality resulting from the law of supply and demand, a gain on sale of an asset could be completely unrelated to the accumulated depreciation and the actual physical wear and tear on the asset. Thus, the Administrator himself is inconsistent in his acceptance of and approach to the concept of economic reality.

It is clear then that if, in the absence of any defining regulation, a concept of economic reality was used to measure costs, the result would be reimbursement policy schizophrenia, with each provider and intermediary applying their own personal concept of economic reality. The wisdom of adopting some common measurement of costs such as GAAP (which the Secretary appears to have done in 42 CFR 405.406) is thus self-evident. The principles of GAAP are carefully defined and are thus less open to interpretation than an undefined concept of economic reality.

Indeed, if the Administrator wishes to discuss and apply sound policy, it is preferable to have Medicare reimbursement principles based on a consistent, uniform standardized method of accounting, even if that method, GAAP, was historically developed to assure uniform financial reporting. Perhaps the best policy would have been for the Secretary to use GAAP as the basis for measuring costs but to have clearly retained through regulation, as the IRS did in *Thor*, the authority to reject GAAP through manual provisions or other policy pronouncements. We acknowledge that the Secretary can and may have provided

for specific exceptions to GAAP through regulation. He also could have given himself the authority to provide for exceptions to GAAP through manual provisions and other policy pronouncements. However, the Secretary never did the latter.

Case law on this subject is frustrating. Different courts have held for providers and the government, but the Board believes that the decisions to date have not clearly defined the crucial issue. They have not clearly distinguished between the test for allowability of a cost and how the cost should be computed. The test for allowability is provided by 42 CFR 405.451—the cost must be necessary and proper and related to patient care. On the other hand, the test for determination of the amount of cost is governed by 42 CFR 405.406 and 453. In this case there is no dispute that the cost is allowable under 42 CFR 405.451. However, the Board holds that the *amount* of the cost should be computed in accordance with 42 CFR 405.406 and 453.

In the Board's previous decisions in *Baptist* and in *Mercy*, the Board adopted the analytic approach set forth in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988). In *Charlotte Memorial* the court addressed the validity of a manual provision prescribing a reimbursement treatment of unfunded deferred compensation plans contrary to the accounting treatment in GAAP. The court clearly stated that it was not deciding the proposition whether the Secretary, in the absence of an enabling regulation, was authorized to prescribe regulatory interpretations that conflict with GAAP. Nevertheless, the court opined that the Secretary, in doing so, would be at the very limit of his authority.

According to the court, such interpretations would be subject to greater scrutiny than interpretations which are consistent with GAAP, because the Secretary does not have to comply with the Administrative Procedure Act when prescribing regulatory interpretations such as those found in HIM 15, the manual provisions. In *Charlotte Memorial* the focus of the scrutiny was,

whether, with respect to the type of medical cost at issue, the departure from GAAP "do not accurately reflect the cost of patient care, as opposed to the cost of running a business", *Villa View*, 720 F2d at n. 18, *Charlotte Memorial*, p. 18, 194.

The Board no longer relies on *Charlotte Memorial* and instead adopts the test set forth above based in part on its understanding of the analytical approach in *Thor* and its belief that it is the correct legal conclusion. Thus, with regard to any type of medical cost at issue, the first step is to determine actual cost as provided by 42 CFR 405.406 and 453. The focus of scrutiny then becomes whether the cost is necessary and proper and related to patient care as required by 42 CFR 405.451.

In conclusion, the Provider's use of GAAP in reporting a loss on defeasance is correct. The Board holds that the loss is allowable under 42 CFR 405.451 and conforms to the requirements found in 42 CFR 405.406 and 42 CFR 405.453 that actual cost be determined using GAAP.

Issue No. 2—Investment Income Offset

The Board finds that the Provider's interest payment account of the DSF qualifies as funded depreciation under 42 CFR 405.419(6)(2)(iii) and PRM section 226. Thus, the investment income earned by this account does not have to be offset against the Provider's allowable interest expense.

In *General Hospital of Everett*, Decision 88-D14, the Board held that a single Debt Service Fund [sic] (used to pay interest and principal) met the requirements of a funded depreciation account. In this case there were two accounts which constituted the Debt Service Fund—one for interest and the other for principal. The Board finds this a difference in form, and not substance. The interest account is so closely related to the borrowing that the Board deems it to be a purpose for which funded depreciation monies can be properly used. However, the Board would not extend that reasoning to the maintenance and insurance accounts required by the bond indenture.

DECISION:

Issue No. 1—Loss on Bond Advance Refunding

The Intermediary's adjustment is reversed. The loss on the advance refunding of the 1972 and 1982 bonds is allowed in full in FY 85.

Issue No. 2—Investment Income Offset

The Intermediary's adjustment is reversed. The interest expense account of the DSF is funded depreciation, and the investment income earned by this account does not have to be offset against the Provider's allowable interest expense.

Board Members Participating:

Elise D. Smith
 Keith E. Braganza
 Sally A. Kirkpatrick

FOR THE BOARD:

AUG 16 1990

/s/ Elise D. Smith
 ELISE D. SMITH
 Chairman

APPENDIX F

Section 233 of the Secretary's Provider Reimbursement Manual provides as follows:

233. ADVANCE REFUNDING OF DEBT

233.1 General.—Advance refunding is a refinancing technique which enables a provider to replace existing debt prior to its scheduled maturity with new debt. This section does not apply to a recall of debt before scheduled maturity without the issuance of new debt. (See § 215, Recall of Debt Before Maturity.) Advance refunding is done for a variety of reasons including achieving a lower interest rate, improving cash flow, removing restrictive covenants, and increasing borrowing capacity. Sections 233.1-233.5 are effective for all refundings initiated on or after July 1, 1983. For purposes of this section, the term "initiated" means either (1) an action taken by the provider which reflects a clear intention to effect the advance refunding (e.g., board resolution empowering the management to proceed with the advance refunding, engagement of an underwriter, application to the debt-issuing authority, etc.), or (2) an official action by the debt-issuing authority reflecting a clear intention to effect the advance refunding.

233.2 Definitions.—For purposes of this section the following definitions apply:

Refunding Debt.—New debt issued to provide funds to replace the refunded debt immediately or at a specified future date(s).

Refunded Debt.—Debt for which payment immediately or at a specified future date(s) has been provided by the issuance of refunding debt.

Advance Refunding.—A transaction in which refunding debt is issued to replace the refunded debt immediately or at a specified future date(s).

Defeasance Provision.—A provision in the refunded debt instrument that provides the terms by which the debt may be legally satisfied and the related lien (if any) released without the debt necessarily being retired.

Defeasance.—Legal satisfaction of debt under the terms of a defeasance provision.

233.3 Allowable Costs.—When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding, the revenues and expenses associated with the advance refunding are treated as follows:

A. Debt issue costs on the refunding debt must be amortized over the life of the refunding debt from the date the debt is incurred to scheduled maturity of the debt. (See §§ 204, 206, 210, and 212.1.)

B. Debt cancellation costs on the refunded debt are allowable as indicated below:

1. Redemption expenses and any other miscellaneous expenses (legal fees, initial trustee fees, feasibility studies, stamp fees, printing, etc.) are allowed as paid or accrued (subject to § 2305);

2. Annual authority and trustee fees are allowed as paid or accrued (subject to § 2305);

3. Call premiums or penalties are allowable in the period(s) the holders of the refunded debt receive the principal payment. Call premiums or penalties of serial bonds should be prorated over the scheduled

maturity or recall dates on the basis of the proportionate principal repayments at each date.

C. Unamortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment (appropriately prorated in the case of serial bonds as in B. above).

D. Interest expense on the refunded debt is allowable on an annual basis as paid or accrued, whether by the provider or by a trust. (See § 2305ff.) Similarly, interest expense on the refunding debt is allowable as paid or accrued. The amortized portion of discounts or premiums on the refunding debt is an adjustment to allowable interest expense in accordance with §§ 212.1 or 214, respectively. The interest income derived from the investment of the proceeds of the refunding debt must be used to offset interest expense in accordance with § 202.2, whether this interest income is earned by the provider directly or through a trust.

The effect of the above treatment is to implicitly recognize any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately. The individual expense elements are the only costs which can be reimbursed in accordance with the above policy.

233.4 Limitation on Recognition of Costs.—As with all costs incurred for funds borrowed, the costs associated with an advance refunding must meet the

necessary and proper tests of §§ 202.2 and 202.3, respectively, as well as the reasonable cost provisions of § 2100ff. In addition, sinking funds available for liquidation of the refunded debt must be considered in a determination of necessary borrowing through advance refunding. On occasion a provider may borrow more than the amount required to advance refund the existing debt. If the additional borrowing is for the acquisition of depreciable assets, existing funded depreciation must be taken into account in determining the necessity of the excess borrowing. Generally, the total net aggregate allowable costs (as described in § 233.3) incurred for all cost reporting periods related to the advance refunding cannot exceed the total net aggregate costs that would have been allowable had the advance refunding not occurred. However, in evaluating the necessity, propriety and prudence of an advance refunding, consideration may be given to factors such as cash flow needs or the necessity to remove a restrictive covenant that prevents the provider from borrowing additional funds for an appropriate purpose.

If the provider incurs excess aggregate costs, as described above, the excess costs will be allowable only where the provider can demonstrate to the satisfaction of the intermediary that compelling factors (such as those mentioned above) necessitated the advance refunding. In cases where the provider cannot make such a satisfactory demonstration, the excess costs are unallowable, and the provider's reimbursement would be limited annually to the costs it would have incurred if the old bonds had not been refunded.

233.5 Treatment of Items for Equity Capital Purposes.—All debts, and proceeds of those debts, asso-

ciated with advance refunding incurred for necessary patient care are includable in the determination of equity capital in accordance with Chapter 12. However, if interest expense is disallowed under the limitation expressed in § 233.4, the debt (or unreasonable portion thereof) associated with the disallowed interest expense, as well as the related assets, must be excluded in the determination of equity capital.

MAR 3 1994

OFFICE OF THE CLERK

No. 93-1251

In The
Supreme Court of the United States
October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari
To The Sixth Circuit Court Of Appeals

**BRIEF FOR THE RESPONDENT IN OPPOSITION
TO PETITION FOR A WRIT OF CERTIORARI**

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QUESTIONS PRESENTED

Petitioner has presented the following questions:

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

The above issues arise from a dispute involving Medicare reimbursement for the costs incurred by Respondent in connection with the advance refunding of bonded indebtedness. It is undisputed that the Respondent is entitled to Medicare reimbursement for the costs in question. The parties, however, dispute when the reimbursement is to be made – in a lump sum in the year of the refunding as required by generally accepted accounting principles ("GAAP") and the Medicare regulations requiring the use of GAAP, or in a series of payments amortized over the remaining life of the refunded bonds as required by Provider Reimbursement Manual Section 233 ("PRM 233").

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On Petition For A Writ Of Certiorari
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BRIEF FOR THE RESPONDENT IN OPPOSITION
TO PETITION FOR A WRIT OF CERTIORARI

JURISDICTION

Respondent does not take issue with the Petitioner
invoking the jurisdiction of this Court under 28 U.S.C.
§ 1254(1).

STATUTORY AND REGULATORY
PROVISIONS INVOLVED

In addition to the statutes and regulations restated in
the Petition for a Writ of Certiorari:

1. Section 1871 of the Social Security Act, 42 U.S.C. § 1395hh(a), provides as follows:

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

2. The Medicare regulation implementing 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. Part 413, provides in pertinent part as follows:

Subpart A - Introduction and General Rules

§ 413.5 Cost Reimbursement: General

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne

by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. * * *

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement. . . .

STATEMENT OF THE CASE

Respondent takes issue with Petitioner's characterization of the loss on advance refunding as an "accounting" loss. The loss incurred in 1985 by Respondent in defeasing its 1972 and 1982 bonds was an actual loss. *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991).

Indeed, there is no dispute in this case that the loss was incurred by Respondent as an actual cost of providing medical services to Medicare beneficiaries since Petitioner agrees that the loss is reimbursable. The advance refunding loss includes the write-off of approximately \$700,000 of unamortized bond discount and financing costs associated with the 1972 and 1982 bond issues. PRRB Hearing Decision, Appendix to Petition for a Writ of Certiorari (hereinafter, "Appendix to Petition"), 56a-57a. These costs were actually paid in full by Respondent in 1972 and 1982, and amortized as interest costs by Respondent over the periods during which Respondent was obligated under the 1972 and 1982 bond issues, which obligations expired in 1985 with the defeasance. The advance refunding loss also includes the payment of a call premium on the 1982 bonds in the approximate amount of \$300,000, which Respondent had to fund out of pocket at the time of the defeasance in 1985. Indeed, Petitioner, at footnote 4 of her Petition for a Writ of Certiorari, admits that the call premium was "payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account" in 1985. Netted against the unamortized bond discount and financing costs and the call premium costs was approximately \$300,000 in interest income earned by the escrow fund for the 1972 and 1982 bonds. The net advance refunding loss of \$672,581 represents actual expenses incurred by Respondent in 1985. These expenses related only to the 1972 and 1982 obligations which were defeased in 1985. For GAAP and Medicare reimbursement purposes these costs must be

reported and reimbursed in full in 1985, the year of defeasance.

Respondent also takes issue with Petitioner's statement that the Provider Reimbursement Review Board ("PRRB") did not directly address the validity of PRM 233. The PRRB specifically observed that "PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component." PRRB Hearing Decision, Appendix to Petition, 70a. The PRRB rejected the Intermediary's use of PRM 233 because the PRRB found that the loss, "as incurred, is allowable under 42 C.F.R. 405.451 [42 C.F.R. § 413.9] – the cost was reasonable, necessary and proper, and related to patient care," and that "[t]he loss was related to patient care in 1985, the year of defeasance." *Id.* at 70a-71a.

Respondent further emphasizes that it is undisputed that the entire amount of the advance refunding loss in issue is an allowable expense for Medicare reimbursement purposes. *See* Decisions of the U.S. Court of Appeals for the Sixth Circuit and the U.S. District Court for the Southern District of Ohio, Appendix to Petition, 2a, 19a-20a. Only the timing of reimbursement is disputed in this case. The District Court's decision reflects this understanding as follows:

The general principles for cost reimbursement are set forth in 42 C.F.R. § 413.5, which provides that "[a]ll necessary and proper expenses of an institution in the production of services . . . are recognized." The parties agree that the refinancing cost incurred by Guernsey Hospital is a cost

which is reimbursable under this general principle. As noted above, the disagreement involves the timing of reimbursement.

District Court Decision, Appendix to Petition, 19a-20a.

The Respondent notes that the court of appeals also stated that the general reimbursement provisions of Part 413 of the Medicare regulations required payment of advance refunding loss in the year of defeasance, relying specifically on the following language from 42 C.F.R. § 413.5(b)(1):

the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

Sixth Circuit Decision, Appendix to Petition, 7a.

REASONS FOR DENYING THE PETITION

Respondent Guernsey Memorial Hospital respectfully requests that this Court deny the Petition for a Writ of Certiorari seeking review of the decision of the United States Court of Appeals for the Sixth Circuit in this case. Contrary to Petitioner's arguments, the court of appeals' decision does not conflict with the decision of any other court of appeals and the court of appeals' approach in interpreting the Medicare regulations does not present serious or disruptive implications for the administration of the Medicare program.

The Petitioner has misstated the holding of the court of appeals. The court of appeals did not hold that the Secretary has effectively delegated to the accounting profession her ultimate authority to determine the amount of reimbursement due a hospital under the Medicare program. Whether the underlying cost is reimbursable is not at issue in this case. The timing of reimbursement is at issue. With respect to this issue, the court of appeals determined, quoting the PRRB decision in this case, that the Medicare regulation

42 C.F.R. § 413.24 requires that cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. Under the accrual basis of accounting, expenses are to be reported in the period in which they are incurred, regardless of when paid. Under the accrual basis of accounting, the loss on defeasance was incurred in the period when the bonds were defeased. The majority of the Board believes that 42 C.F.R. § 413.24 requires that the Secretary determine cost on the accrual basis unless a specific regulation to the contrary has been promulgated.

Sixth Circuit Decision, Appendix to Petition, 13a.

The decision of the court below is consistent with the applicable Medicare statutes and regulations and with the overwhelming weight of authority interpreting those statutes and regulations.

There Is No Conflict Among the Circuit Courts of Appeals

The court of appeals' decision that Medicare regulations require the use of accrual accounting and GAAP principles to determine the period in which costs are reimbursed and that accrual accounting principles and GAAP require that the loss on defeasance be recognized in the year of defeasance does not conflict with the decision of any other court of appeals. Petitioner attempts to create a conflict among the courts of appeals by misstating the decision of the court of appeals in this case. At page 11 of the Petition for a Writ of Certiorari, Petitioner states that "[t]he court of appeals' holding rests on its conclusion that two of the Secretary's general Medicare reimbursement regulations, 42 C.F.R. 413.20 and 413.24, mandate the use of GAAP to determine *allowable* costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue." (emphasis added) Petitioner confuses the issue of cost allowability with the issue of the timing of reimbursement for allowable costs. The court of appeals' decision states that it is undisputed that the defeasance costs in question are allowable, but that there is a dispute as to the timing of reimbursement. Sixth Circuit Decision, Appendix to Petition, 2a.

Petitioner cites the decisions of the courts of appeals in *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542 (9th Cir. 1990), *cert. denied*, ___ U.S. ___, 111 S.Ct. 2014, 59 U.S.L.W. 3769 (1991); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, *cert. denied*, 469 U.S. 823 (1984); *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130 (D.C. Cir. 1982); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701

(9th Cir. 1980); and *Methodist Hosp. of Indiana, Inc. v. United States*, 626 F.2d 823 (Ct. Cl. 1980), as in conflict with the decision below. The decisions cited by Petitioner address whether or not a certain type of cost is allowable. Specifically, *Sun Towers, Inc.* and *National Medical Enterprises* determined that stock maintenance costs were not reimbursable costs because they were not related to patient care as required by 42 C.F.R. § 413.9. Similarly, *Richey Manor, Inc.* determined that stock purchase expenses were not reimbursable costs because they were not related to patient care.¹ *North Clackamas Community Hosp.* disallowed Medicare reimbursement for that portion of the purchase price of a facility that was allocated to the going concern value because a specific Medicare regulation, 42 C.F.R. § 413.157(b), provided that payment for good will was not a reasonable cost allowable by the Medicare program. Finally, *Methodist Hosp.* determined that pension costs, although generally allowable, were properly disallowed in the case before it because the hospital had failed to comply with the required accrued pension trust document. The court in *Methodist Hosp.* found that the hospital's failure to comply with the pension trust document meant that the hospital "did not actually incur the pension cost." *Methodist Hosp.*, 626 F.2d at 825. The *Methodist Hosp.* court expressly limited its holding to that situation in which the hospital violated the pension plan funding requirements. *Id.* at 825, n. 8.

¹ The United States District Court for the District of Columbia in *The Methodist-Evangelical Hosp., Inc. v. Shalala, Medicare & Medicaid Guide (CCH) ¶ 42,017* (D.D.C. 1993), rejected the Secretary's argument that *Richey Manor, Inc.* supports the Secretary's position in the advance refunding issue before this Court.

Each of the cases cited by Petitioner as being in conflict with the decision below addresses the issue of reimbursability. In this case the reimbursability of the advance refunding costs is not in dispute. As recently stated by the district court in *The Methodist-Evangelical Hosp., Inc., supra*, at 8: "[E]ach of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement. *Guernsey* teaches that GAAP governs reimbursement timing and is what is at issue here."

Indeed, in footnote 9 of the Petition for a Writ of Certiorari, Petitioner admits that there is not a conflict among the courts of appeals regarding the application of GAAP in the context of advance refunding transactions. Rather than a conflict, a consensus exists among the federal courts on the application of GAAP in advance refunding transactions. The following federal courts have considered the precise legal issue before the court below and have held consistent with the court below that Medicare regulations require the application of GAAP in advance refunding transactions: *The Methodist-Evangelical Hosp., Inc., supra*; *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D.Ill. 1993); *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. 1993); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hosp., supra*; *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D.Ill. 1985). The only decision of a federal court to affirm the Secretary's amortization of advance refunding costs is *Mother Frances Hosp. v. Shalala*, 818 F.Supp. 990 (E.D.Tex. 1993).² The

² The decision in *Mother Frances Hosp.* is pending before the Fifth Circuit Court of Appeals. Contrary to the Petitioner's

PRRB³ also has consistently taken the position that Medicare regulations require the application of GAAP in advance refunding transactions.⁴

In short, it is obvious that there is no conflict at all among the circuit courts on this issue. Rather, federal courts have consistently ruled that the Medicare regulations require that an advance refunding loss be reimbursed in the year of the defeasance.

argument, however, there is no reason to believe that the Fifth Circuit will affirm this decision on the basis of its decision in *Sun Towers, Inc., supra*. As explained above, *Sun Towers, Inc.* involved the issue of allowable costs rather than the issue of timing for the reimbursement of allowable costs.

³ The PRRB is a board "composed of five members . . . knowledgeable in the field of payment of providers of services" created by the Medicare statute to mediate Medicare disputes. 42 U.S.C. § 1395oo(h).

⁴ The PRRB decided in favor of the provider in each of the advance refunding cases decided by the district courts, which have been cited in the text above. The PRRB also has decided in favor of the provider in the following cases, which present the identical issue present in this case: *Dominican Santa Cruz Hosp., Santa Cruz, Ca. v. Blue Cross*, Medicare & Medicaid Guide (CCH) ¶ 40,120 (PRRB 1990); *Michigan Osteopathic Medical Ctr. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 40,369 (PRRB 1992); *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 40,413 (PRRB 1991); *St. Mary's Regional Medical Ctr. v. Aetna Life Ins. Co.*, Medicare & Medicaid Guide (CCH) ¶ 41,583 (PRRB 1993); *University of Michigan Hosps. v. Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 41,743 (PRRB 1993).

The Decision of the Court of Appeals Is Consistent With the Medicare Act and Regulations

Petitioner argues that her application of PRM 233 finds support in that portion of the Medicare Act defining reasonable cost, 42 U.S.C. § 1395x(v)(1)(A). The Petitioner's argument, however, is without merit because Section 1395x(v)(1)(A) directs the Petitioner to promulgate regulations to determine reasonable cost and, in promulgating such regulations, to consider the "principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment. . . ."

The Petitioner has promulgated such regulations at 42 C.F.R. Part 413, and those regulations expressly adopt "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields," and provide that "[c]hanges in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement." 42 C.F.R. § 413.20(a). The regulations also provide that "cost data must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(a). These provisions and other provisions of the Medicare cost reimbursement regulations at 42 C.F.R. Part 413 have been consistently interpreted by the courts to require the use of GAAP in determining the timing of Medicare cost reimbursement in the absence of a regulation to the contrary. See *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *Charlotte Memorial Hosp. & Medical Ctr. v.*

Bowen, 860 F.2d 595 (4th Cir. 1988); *Lexington County Hosp. v. Schweiker*, 740 F.2d 287 (4th Cir. 1984); *Villa View Community Hosp. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983); *The Methodist-Evangelical Hosp., Inc.*, *supra*; *St. John's Hosp.*, *supra*; *Baptist Hosp. East*, *supra*; *Mercy Hosp.*, *supra*; *Ravenswood Hosp. Medical Ctr.*, *supra*; *Cabrini Medical Ctr. v. Schweiker*, Medicare & Medicaid Guide (CCH) ¶ 30,961 (D.D.C. 1981); and *Ornda Healthcorp v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,975 (E.D. Ark. 1993). PRM 233 departs from the accrual method of accounting and GAAP by deferring reimbursement for advance refunding costs to periods after those costs were incurred. PRM 233 thus conflicts with the Medicare regulations defining reasonable cost by providing for reimbursement of costs which are no longer incurred by the provider.

Petitioner attempts to confuse the issue before this Court by proclaiming that the national organizations contemplated by the Medicare Act's definition of reasonable cost were health oriented organizations such as the American Hospital Association ("AHA"), rather than national accounting organizations. Petitioner relies upon AHA publications as support for her argument that GAAP is not mandated by the regulations. These publications, however, do not support the Petitioner's position. To the contrary, as noted by Petitioner at footnote 10 of the Petition for a Writ of Certiorari, the AHA *Principles of Payment for Hospital Care* states that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting." This concept is virtually identical to the language of 42 C.F.R. § 413.20(a), which states "[s]tandardized definitions, accounting, statistics, and reporting practices that

are widely accepted in the hospital and related fields are followed." Likewise, the "Purpose and Scope" section of AHA *Uniform Chart of Accounts and Definitions for Hospitals* (1959), which is cited by Petitioner in her Petition at pp. 16-17, reveals that the AHA has adopted the accrual basis of accounting.

Similarly, the comments of Social Security Commissioner Ball, as reflected at page 198 of Appendix D to the 1966 *Congressional Hearing on Principles of Medicare Reimbursement*, confirm that "the determination of reimbursable cost does require the acceptance and use of uniform definitions, accounting, statistics, and reporting." The accrual basis of accounting required by the AHA and adopted by Petitioner in her regulations at 42 C.F.R. Part 413 support the decision of the court of appeals in this action.

The Petitioner's argument that the regulations relied on by the court below provide no support for its holding ignores the plain language of 42 C.F.R. §§ 413.5, 413.20, and 413.24. Section 413.5(b)(1) of "Cost Reimbursement: General," which Petitioner fails to discuss as a basis for the holding below, identifies the following objective of cost reimbursement:

That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

The amortization requirement of PRM 233 directly contradicts the current payment requirement of Section 413.5. It is undisputed in this case that the Respondent

has paid the costs at issue prior to or in the year of the bond defeasance. It is further undisputed that the defeasance released all obligation of the Respondent under the defeased bonds. The loss on advance refunding was incurred in the year of defeasance to secure release from Respondent's obligation under the defeased bonds. Once all obligations of Respondent were released, there were no costs related to the defeased bonds that could be ascribed to periods after the defeasance.

The amortization requirement of PRM 233 likewise contradicts Section 413.20(a), which requires that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields" will be followed, and that "[c]hanges in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement." (emphasis added) This regulatory provision means that the Medicare program must pay reimbursable costs based on GAAP principles. Section 413.20(a) further provides that costs are determined from the provider's "basic accounts, as usually maintained." Once a refunded debt has been extinguished, it no longer appears as an obligation on the provider's books and there are no costs to the provider in future years related to this obligation or the refunding transaction. PRM 233 would create an accounting fiction not required by GAAP or the Petitioner's regulations.

The Petitioner's suggestion that 42 C.F.R. § 413.20 is ambiguous is not supported by any authority. Indeed, none of the many courts reviewing this regulation has found it ambiguous. See *Charlotte Memorial Hosp. & Medical Ctr., Inc., supra*; *Villa View Community Hosp., Inc., supra*;

St. John's Hosp., supra; The Methodist-Evangelical Hosp., Inc., supra; Baptist Hosp. East, supra; Mercy Hosp., supra; Ornda Healthcorp, supra; and Ravenswood Hosp. Medical Ctr., supra. Likewise, the PRRB, the board created by the Medicare Act to resolve reimbursement disputes, has consistently found the plain language of Section 413.20 to require current reimbursement of advance refunding losses in every advance refunding case before it.⁵ Finally, there is no authority for Petitioner's argument that the language of Section 413.20 should be disregarded because that regulation, as originally enacted, was placed at the end of a series of prefatory sections of the initial Medicare regulations.

The amortization requirement of PRM 233 also contradicts 42 C.F.R. § 413.24(a), which provides that Medicare cost data "must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(b)(2) states: "Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." Under the accrual basis of accounting advance refunding losses are incurred in the year of the refinancing.

The Petitioner's suggestion that GAAP embodies a "particular version" of accrual accounting is without any support. Accrual accounting is the standardized basis of

⁵ *Dominican Santa Cruz Hosp., Santa Cruz, Ca., supra; Michigan Osteopathic Medical Ctr., supra; Fort Worth Osteopathic Medical Ctr., supra; St. Mary's Regional Medical Ctr., supra; University of Michigan Hosps., supra.*

revenue and cost reporting. It is standardized so that costs of different organizations and of different periods will be comparable.⁶ There are no "versions" of accrual accounting. The suggestion that different versions of accrual accounting exist has never been made prior to the Petition for a Writ of Certiorari. To the contrary, it has been "undisputed in the case at bar that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting." Sixth Circuit Decision, Appendix to Petition, 7a. The *post hoc* rationalizations of appellate counsel cannot be accepted as support for Petitioner's departure from the accrual basis of accounting. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

The Petitioner's argument that Section 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary in determining allowable costs in a given period ignores the plain language of the regulation. Section 413.24, by its terms, governs "cost finding" for Medicare reimbursement purposes. As explained by the regulation: "Cost finding is the process of recasting

⁶ Similarly, the Petitioner's suggestion that Section 233 is consistent with accrual accounting because prior to the adoption of Accounting Principles Board Opinion No. 26 ("APB 26") there was some support among the accounting profession for the amortization of bond defeasance costs is without merit. As stated in APB 26, the Opinions of the APB represent the conclusion of at least two-thirds of the members of the APB, and as promulgated must be applied in all circumstances. Thus, once adopted, APB 26 defined accrual accounting treatment for bond defeasance costs.

the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished." 42 C.F.R. § 413.24(b)(1). Section 413.24 requires the "recasting" of reported provider data and requires that the recasting be performed using approved methods of cost finding and the accrual basis of accounting.

The Petitioner's argument that the court of appeals erred in concluding that the Secretary is required to apply GAAP in adjudicating Medicare reimbursement claims in the absence of a specific regulation to the contrary is inconsistent with the position taken by the Secretary in those cases in which GAAP supports the Petitioner's position. For example, in *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d at 1180, "[t]he Secretary refused reimbursement on the ground that under 'generally accepted accounting principles' (which the Secretary is mandated to apply where an issue has not been covered by agency regulations, 42 C.F.R. § 405.405 [42 C.F.R. § 413.60]) there were no reasonable costs incurred." (emphasis added) The decision in that case also observed that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply 'generally accepted accounting principles.'" *Id.* at 1181. Thus, Petitioner's position in this action is not only inconsistent with the Medicare cost reimbursement regulations but also with Petitioner's prior interpretation of those regulations.

The Petitioner's argument that the reimbursement of a loss on advance refunding in a single year will result in cross-subsidization by Medicare of non-Medicare patients is without merit and has been consistently rejected by the

courts. As explained by the court in *Mercy Hosp., supra*, at 12:

The Secretary's cross-subsidization argument rests on a faulty premise. The regulations cited by the Secretary relate to reasonableness of claimed costs. There has been no allegation that the Hospital has not properly allocated the claimed costs between Medicare and non-Medicare patients. The parties have agreed that the costs are reasonable and the only outstanding issue is timing: when should reimbursement be made.

The PRRB also has explained that the loss on advance refunding relates solely to patient care in the year of defeasance, and thus gives rise to no cross-subsidizations between periods:

The loss was related to patient care in the year of defeasance. The Board majority finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically as losses or gains. Thus, there would have been no loss on the extinguishment of the debt. For that reason, the entire loss on defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Fort Worth Osteopathic Medical Ctr., supra, at 31,844-31,845.

The Petitioner relies on the cost allocation principles underlying asset depreciation and amortization to support her cross-subsidization argument. The Petitioner's reliance is misplaced. In the case of depreciation and amortization of capital assets, there is an asset on the books of the provider. The cost of using that asset is spread over the periods during which that asset remains on the books of the provider. There is no accepted accounting practice that would permit capitalizing and then amortizing an asset that is no longer in the possession of the provider or a liability that is no longer the obligation of the provider.

The Petitioner also appears to imply, at footnotes 11 and 13 of the Petition for a Writ of Certiorari, that the accrual accounting principles of APB 26, as applied by the court below, are inappropriate in the context of a government health care cost reimbursement program. The Petitioner cites Statements of the Governmental Accounting Standards Board in support of her position. The Statements of the Government Accounting Standards Board have no relevance to the issues of this case. Those standards apply only to government institutions, which sometimes use a cash basis of accounting rather than an accrual basis of accounting. The Medicare regulations provide for an exception to accrual accounting for certain governmental institutions at 42 C.F.R. § 413.24(a), as follows:

However, if governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

It is undisputed that Respondent is not a governmental institution. Accrual accounting principles, rather than the cash accounting principles of the Statements of the Government Accounting Standards, govern reimbursement of Respondent's costs. Thus, Petitioner's reliance on the Statements of the Government Accounting Standards Board is misplaced.

PRM 233 Is a Substantive Rule That Was Promulgated Without Complying With the APA Rule-Making Requirements

The Petitioner's argument that PRM 233 is an interpretative rule, rather than a substantive rule, is based upon the assumption that 42 C.F.R. §§ 413.20 and 413.24 do not require adherence to GAAP for purposes of Medicare reimbursement. This assumption is not supported by the language of those regulations or of 42 C.F.R. § 413.5, and is not supported by the overwhelming weight of the decisional law interpreting those regulations in advance refunding transactions, as discussed above. Even if, however, the Petitioner's assumption were accepted, PRM 233 would constitute a substantive rule because its amortization treatment of advance refunding losses departs from the accrual basis of accounting required by 42 C.F.R. §§ 413.5, 413.20, and 413.24.

The Petitioner argues that PRM 233 is merely interpretative of the capital-related cost reimbursement provisions of 42 C.F.R. §§ 413.9, 413.130, and 413.153. The Petitioner made a similar argument in *The Methodist-Evangelical Hosp., Inc., supra*, at 6, as follows:

The Secretary contends that the departure of the Section 233 amortization requirement from GAAP merely interprets existing regulations. She points to 42 C.F.R. §§ 413.5 and 413.9, which tie reimbursement generally to the actual cost of caring for Medicare beneficiaries in a single year, as well as § 413.153 on reimbursement of interest expense.

In rejecting this argument the court in *The Methodist-Evangelical Hosp.* applied the following four-part test from *American Mining Congress v. Mining Safety & Health Admin.*, 995 F.2d 1106, 1112 (D.C. Cir. 1993), for determining whether a rule is interpretive or substantive:

(1) whether in the absence of the rule there would not be an adequate legislative basis for enforcement action or other agency action to confer benefits or ensure the performance of duties, (2) whether the agency has published the rule in the Code of Federal Regulations, (3) whether the agency has explicitly invoked its general legislative authority, or (4) whether the rule effectively amends a prior legislative rule. If the answer to any of these questions is affirmative, we have a legislative, not an interpretive rule.

The court in *The Methodist-Evangelical Hosp., Inc.* found that as to PRM 233 the first and the fourth of these questions must be answered in the affirmative, because, inter alia, "Section 233 also 'amends' §§ 413.20 and 413.24 by adding an exception to the application of generally accepted principles." *The Methodist-Evangelical Hosp., Inc.*, *supra*, at 7.

This Court in *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979), defined a substantive rule as one "affecting individual rights and obligations." The Court described this characteristic as the "touchstone" for distinguishing between substantive and interpretative rules. *Id.* PRM 233 requires providers to amortize a loss on advance refunding over the remaining term of a debt, after the provider has been released of any further obligation on the debt. PRM 233 does not refer to any statutes or regulations authorizing its departure from accrual accounting principles, and the obligation it imposes on providers to defer their advance refunding loss is not imposed by any statute or regulation. Rather, PRM 233 creates a complicated set of new rules that alter the accounting treatment of the losses and gains incurred as the result of an advance refunding transaction. PRM 233 effects a fundamental change in accrual accounting principles. That change imposes record keeping and reporting obligations inconsistent with accrual accounting, defers the provider's right to reimbursement of current costs, and results in a decrease of current Medicare reimbursement, in Respondent's case in the amount of \$314,000. Clearly, PRM 233 affects individual rights and obligations, thereby falling within the definition of substantive rule. See, *Mercy Hosp.*, *supra*, at 16 ("These PRM sections [Sections 215, 215.1 and 233] substantively change the Secretary's accrual regulatory procedures into amortization procedures.").

The APA rule-making requirements for substantive rules are particularly applicable to Medicare rules used to determine reasonable costs. The Medicare statutory provision that defines "reasonable cost" provides that "[t]he

reasonable cost of any services . . . shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services. . . ." 42 U.S.C. § 1395x(v)(1)(A). (emphasis added) The reasonable cost regulations in effect at 42 C.F.R. Part 413 require the use of GAAP and accrual accounting principles. PRM 233 departs from GAAP and accrual accounting principles in the timing of reimbursement for advance refunding losses.

There is also a specific Medicare statute that requires the Secretary to proceed by rule making when prescribing substantive rules. 42 U.S.C. § 1395hh(a)(2) provides that:

No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . under this subchapter shall take effect unless it is promulgated by the Secretary by regulation. . . .

This part of the statute was not in effect when PRM 233 was adopted by the Secretary. However, it indicated Congress' understanding that manual provisions such as PRM 233 that establish or change the legal standard or govern the payment for services are ineffective unless adopted pursuant to rule-making procedures.

The Decision of the Court Below Will Not Disrupt the Medicare Program

The Medicare regulations governing cost reimbursement require the use of the accrual basis of accounting and GAAP in determining the reimbursement of allowable costs. PRM 233 departs from the accrual basis of accounting and GAAP. The court below correctly determined that PRM 233 was inconsistent with existing Medicare regulations and therefore void. This holding is consistent with Medicare regulations and with relevant case law interpreting those regulations. Contrary to Petitioner's argument, there is no conflict among the courts of appeals on this issue.

The Petitioner would have this Court allow her to depart from accrual accounting principles and GAAP without complying with the APA rule-making procedures in this instance because substantial Medicare payments are at stake. This argument only undermines the Petitioner's argument that PRM 233 is not a substantive rule. The Petitioner's argument conclusively demonstrates that PRM 233 significantly impacts the rights of providers, and should be applied only after compliance with rule-making procedures.

The requirement that Petitioner proceed by rule making as provided by the APA is well-grounded and accepted by the courts. The notice and comment procedures have been found by the courts to help

assure that the correct rules are established in the first instance. As this court has explained, "public participation assures that the agency will have before it the facts and information

relevant to a particular administrative problem . . . [and] increase[s] the likelihood of administrative responsiveness to the needs and concerns of those affected."

American Hosp. Ass'n v. Bowen, 834 F.2d 1037, 1061 (D.C. Cir. 1987) (citations omitted). The *American Hosp. Ass'n* court further noted that rule making enables "the agency promulgating the rule to educate itself before establishing . . . procedures which have a substantial impact on those regulated." *Id.* (citation omitted).⁷

The effect of finding PRM 233 to be an interpretative rule would be to allow the Petitioner to avoid compliance with the APA and its rule-making requirements, as well as to avoid compliance with the accrual accounting requirements of the Petitioner's cost reimbursement regulations. The court below was correct in holding that the "Secretary may not promulgate regulations and then change their meanings by interpretations or clarifications without formal notice or comment." Sixth Circuit Decision, Appendix to Petition, 10a, quoting *Mercy Hosp. v. Sullivan*, *supra*.

⁷ See also *Chamber of Commerce of the United States v. OSHA*, 636 F.2d 464, 470 (D.C. Cir. 1980) ("Prior notice and an opportunity to comment permit [affected parties] to voice their objections before the agency takes final action," and "public scrutiny and participation before a legislative rule becomes effective can reduce the risk of factual errors, arbitrary actions, and unforeseen detrimental consequences").

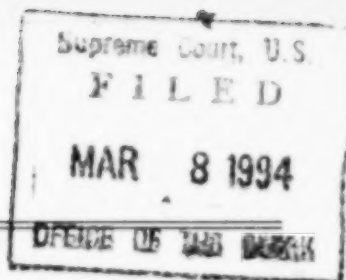
CONCLUSION

The decision of the court below is consistent with the Medicare statutes and regulations and with the rule-making requirements of the APA. The decision of the court below is not in conflict with the decision of any other court of appeals, but instead is supported by the overwhelming weight of authority. The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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No. 93-1251



In The
Supreme Court of the United States
October Term, 1993

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari
To The Sixth Circuit Court Of Appeals

**SUPPLEMENTAL BRIEF FOR THE
RESPONDENT IN OPPOSITION TO PETITION
FOR A WRIT OF CERTIORARI**

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SUPPLEMENTAL BRIEF

Respondent hereby submits this Supplemental Brief, pursuant to Rule 15.7 of the Rules of the Supreme Court of the United States, to make this Court aware of a new federal court of appeals decision applicable to this matter.

On March 3, 1994, the United States Court of Appeals for the Fifth Circuit handed down its decision in *Mother Frances Hosp. of Tyler, Texas v. Shalala*, ___ F.3d ___, No. 93-4388, 1994 WL 45159 (5th Cir. 1994), holding that a hospital was entitled to have the Medicare portion of its refinancing loss reimbursed in the year such loss was incurred, rather than in amortized payments over a period of years. The Fifth Circuit reversed the ruling of the district court which had held that, for Medicare reimbursement purposes, the hospital's advance refunding loss must be amortized over the remaining life of the refunded bonds. A copy of the Fifth Circuit's decision in *Mother Frances* is included herein as Appendix A.

Based on the Sixth Circuit's decision in this matter and the other abundant federal case law all holding against the Petitioner on this precise issue, the Fifth Circuit in *Mother Frances* rejected the Petitioner's argument that an advance refunding loss must be amortized. The Fifth Circuit noted:

This argument by the Secretary has not fared well in the federal courts. Aside from the decision by the district court herein, every district court to have addressed the issue of the timing of reimbursement for an advance refunding loss has held, consistent with GAAP [generally accepted accounting principles] and contrary to the Secretary's argument, that this

loss is immediately reimbursable. Further, this issue was thoroughly discussed and the Secretary's arguments were rejected by the Sixth Circuit in *Guernsey Memorial Hosp. v. Secretary of Health and Human Services*, 996 F.2d 830 (6th Cir. 1993).

Mother Frances, 1994 WL 45159 at *2. Two federal courts of appeal and five federal district courts have all unanimously ruled against the advance refunding treatment which the Petitioner continues to advance here. *Id.* at *4, n.7. Thus, there are now no federal court decisions accepting the Petitioner's position.

The Fifth Circuit further found that *Guernsey Memorial* was on "all fours" and fully embraced the reasoning in that decision:

We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that [Provider Reimbursement Manual] section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities.

Id. at *2-3. This directly refutes the suggestion at pages twelve and thirteen of the Petition for a Writ of Certiorari filed herein that a "conflict" exists between the Fifth and Sixth Circuits regarding the proper Medicare treatment of an advance refunding loss.

Finally, the Fifth Circuit distinguished its prior ruling in *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir. 1984),

cert. denied, 469 U.S. 823 (1984). On this point, the Fifth Circuit asserted:

In *Sun Towers*, the issue was whether a particular cost was allowable [reimbursable] at all. In the case at bar, as it was in the *Guernsey* case, the issue is when a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that *Sun Towers* speaks to the issue of when reimbursement is to be made.

Mother Frances, 1994 WL 45159 at *3. This analysis is equally applicable herein to Petitioner's reference to *Sun Towers* and other inapposite reimbursement cases on pages thirteen and fourteen of her Petition for a Writ of Certiorari.

For the above reasons and those already set forth in its Brief in Opposition, Respondent respectfully requests that this Court deny the Petition for a Writ of Certiorari.

Respectfully submitted,

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- F.3d -

1994 WL 45159 (5TH CIR. (TEX.))

MOTHER FRANCES HOSPITAL OF TYLER, TEXAS,
Plaintiff-Appellant,

v.

Donna E. SHALALA, in her official capacity as
Secretary of the Department of Health and Human
Services and William Toby, Jr., in his official capacity
as Acting Administrator of the Health Care Financing
Administration,
Defendants-Appellees.

No. 93-4388.

United States Court of Appeals,
Fifth Circuit.

March 3, 1994.

Medicare provider hospital appealed determination of administrator of Health Care Financing Administrator that hospital's refinancing loss, incurred through defeasance of debt by early retirement of series of bonds, was required to be amortized, rather than immediately refunded through Medicare program. The United States District Court for the Eastern District of Texas, William Wayne Justice, J., 818 F.Supp. 990, granted summary judgment for Secretary of Health and Human Services. Hospital appealed. The Court of Appeals, Johnson, Circuit Judge, held that hospital was entitled to have its refinancing loss reimbursed in one lump sum during year in which it incurred loss, rather than in amortized payments over period of years.

Reversed and remanded.

Dan M. Peterson, Thomas E. Dowdell, Fulbright & Jaworski, Washington, DC, for Mother Frances Hosp.

John P. Schnitker, Anthony John Steinmeyer, Dept. of Justice, Civ.Div., Washington, DC, Bob Worthham, U.S. Atty., Office of Gen. Counsel, Dept. of H.H.S., Dallas, TX, for defendants-appellees.

Appeal from the United States District Court for the Eastern District of Texas.

Before JOHNSON, GARWOOD, and JOLLY, Circuit Judges.

JOHNSON, Circuit Judge:

*1 The dispute in this case concerns the timing of Medicare reimbursement payments for costs incurred by provider hospitals under the Medicare Program. The particular costs at issue herein stem from an "advance refunding" transaction conducted by Mother Frances Hospital of Tyler, Texas (the "Hospital") in 1987. In that transaction, the Hospital incurred "defeasance" costs when it refunded an old series of bonds ahead of schedule in order to obtain new financing. All parties agree that these costs are reimbursable. The only issue that is contested is when and how this reimbursement is to be made. The Hospital maintains that such a loss is reimbursable immediately in a lump sum. By contrast, the Secretary of Health and Human Services (the "Secretary") contends that reimbursement should be amortized over the life of the old bonds. The district court ruled in favor of the Secretary. We REVERSE.

I.

FACTS AND PROCEDURAL HISTORY

In 1987, the Hospital borrowed money by issuing a new series of bonds. Most of the proceeds of this 1987 bond issue were used in an "advance refunding" transaction to refinance an earlier, 1983 bond issue. In this transaction, the Hospital placed the funds from the new bond issue into an irrevocable trust account under the direction of an independent trustee. The trustee invested this money in U.S. Treasury obligations at an interest rate sufficient to pay the principal and interest of the old bonds as they came due. By means of this transaction, the Hospital was able to transfer its legal liability for the 1983 bonds to the trustee. Thus, the Hospital's liability for the bonds was "defeased."

As a result of this transaction, the Hospital incurred a loss.¹ This loss occurred because in order to create a sufficient fund in the trust to service the old bonds, the Hospital had to borrow a greater principal amount in the new bond issue.² Thus, after the 1987 transaction, the Hospital had a greater debt.³

¹ This loss amounted to in excess of \$11 million of which Medicare will reimburse approximately \$4 million.

² Also added to this loss were certain up-front transactional costs the Hospital incurred in this transaction.

³ Even though this transaction would result in a greater debt for the Hospital, it still made economic sense because, owing to lower interest rates, the new financing could be obtained on more favorable terms than the old financing. Thus, in reality, the Hospital would end up with a net economic gain because of reduced interest expense.

Acting in accordance with Generally Accepted Accounting Principles (GAAP)⁴, as is required by 42 C.F.R. § 413.20, the Hospital sought reimbursement for this entire loss in 1987. This request was denied, though, by the "fiscal intermediary"⁵ to which such requests are initially routed. Instead, the intermediary allowed only a portion of this loss in 1987 and sought to space out the remaining reimbursement by amortizing it over the life of the old bonds. The Hospital appealed this decision to the Provider Reimbursement Review Board, a body established by the Secretary pursuant to 42 U.S.C. § 1395oo to

⁴ GAAP consists of the three official publications of the American Institute of Certified Public Accountants (AICPA). These publications are the Accounting Principles Board Opinions, the Financial Accounting Standards Board statements, and the Accounting Research Bulletins. See *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 n. 3 (9th Cir.1989). In 1972, the Accounting Principles Board issued APB Opinion 26 which is entitled "Early Extinguishment of Debt." This opinion states that "[a] difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains and identified as a separate item. . . . Gains and losses should not be amortized to future periods." Opinion 26, P 20.

⁵ The Medicare program provides for the payment of inpatient hospital and related post-institutional care for eligible individuals. These medical services are rendered by provider hospitals which participate in the Medicare program by entering into a "provider agreement" with the Secretary. 42 U.S.C. §§ 1395x(u), 1395cc. The Secretary then reimburses those provider hospitals through a "fiscal intermediary." 42 U.S.C. §§ 1395g, 1395h. In this case, the fiscal intermediary was Blue Shield of Texas, Inc.

hear these appeals. Finding that the regulations implementing the Medicare program provided for the use of GAAP in the absence of specific regulations to the contrary, the Board reversed the decision of the intermediary and issued a decision calling for full reimbursement in 1987.

The Board's decision was, in turn, reviewed by the Administrator of the Health Care Finance Administration. In making his decision, the Administrator relied on a policy announced in section 233 of the agency's Provider Reimbursement Manual (PRM) calling for amortization of advance refunding costs. Accordingly, the Administrator reversed the decision of the Board. Under 42 C.F.R. § 405.1875, this decision represented the final decision of the Secretary.

*2 From this decision the Hospital appealed to the district court where arguments were heard before a magistrate judge. The magistrate judge issued a Report and Recommendation in favor of the Hospital finding that section 233 was no more than a manual provision without the force and effect of law and thus was ineffective to change the meaning of the governing regulations, 42 C.F.R. § 413.20(a) and 413.24(a) and (b)(2), which call for the use of GAAP. This recommendation was rejected by the district judge, however, who found that section 233 was merely interpretive of the regulations and was therefore valid. Hence, the district court granted summary judgment for the Secretary, 818 F.Supp. 990. The Hospital timely appeals from this decision.

II.

DISCUSSION

Under the Medicare statute, the Secretary must reimburse provider hospitals for the reasonable costs of services rendered to eligible Medicare beneficiaries. The calculation of these reasonable costs "shall be determined in accordance with regulations establishing the method or methods to be used. . . ." 42 U.S.C. § 1395x(v). Moreover, "[i]n prescribing the regulations, the Secretary shall consider, among other things, the principles generally applied by national organizations. . . ." *Id.* These "national organizations" utilize GAAP.

This statute only states that the Secretary must "consider" GAAP in making regulations. It does not say that she must pass regulations adopting GAAP. However, under 42 C.F.R. § 413 et seq., entitled "Principles of Reasonable Cost Reimbursement," she appears to have done so. Under section 413.20(a), the regulations state that

[t]he principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed (emphasis added).

Moreover, section 413.24(a) states that "[t]he cost data must be based on an approved method of cost finding and on the accrual basis of accounting." Lastly, section 413.24(b) (2) instructs that

[u]nder the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid (emphasis added).

In light of GAAP, the manifest conclusion from reading these regulations is that the Hospital was entitled to full reimbursement for this advance refunding loss in 1987.

Nevertheless, the Secretary seeks to avoid this result. She argues that the regulations merely provide for GAAP with respect to a hospital's reporting of its costs and do not compel a result with respect to the timing of cost reimbursement. Instead, she maintains that the timing of cost reimbursement in advance refunding transactions should be covered by PRM § 233. This provision speaks directly to advance refunding transactions and, contrary to GAAP, clearly provides for amortization of the loss.⁶

*3 This argument by the Secretary has not fared well in the federal courts. Aside from the decision by the district court herein, every district court to have addressed the issue of the timing of reimbursement for an

⁶ Specifically, this section, instructs that: When a provider defeases or repurchases debt incurred for necessary patient care through an advance refunding . . . [u]namortized discounts or premiums (reduction of debt cancellation costs) and debt issue costs of the refunded debt must be amortized over the period from the issue date of the refunding debt to the date the holders of the refunded debt will receive the principal payment . . . "

advance refunding loss has held, consistent with GAAP and contrary to the Secretary's argument, that this loss is immediately reimbursable.⁷ Further, this issue was thoroughly discussed and the Secretary's arguments were rejected by the Sixth Circuit in *Guernsey Memorial Hosp. v. Secretary of Health and Human Services*⁸, 996 F.2d 830 (6th Cir.1993).

In *Guernsey*, a case on all fours with the case sub judice, the Sixth Circuit determined that the language and structure of the Medicare regulations unambiguously provide that reimbursement will be made on the basis indicated by GAAP. *Id.* at 835. Specifically, the court found that

[w]ere it not for § 233 of the Provider Reimbursement Manual, any fair minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that [the hospital] was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Id. at 834.

⁷ *Graham Hospital Ass'n v. Sullivan*, 832 F.Supp. 1235, 145 (N.D.Ill.1993); *Baptist Hospital East v. Sullivan*, 767 F.Supp. 139 (W.D.Ky.1991); *Mercy Hospital v. Sullivan*, Civil No. 90-0024 P, 1991 WL 104090 (D.Me. April 25, 1991); *Ravenswood Hospital Medical Ctr. v. Schweiker*, 622 F.Supp. 338 (N.D.Ill.1985); *Methodist-Evangelical Hospital, Inc. v. Shalala*, Civil No. 92-2887-LFO, 1993 WL 548830 (D.D.C. Dec. 22, 1993); *Grant Medical Center v. Shalala*, Civil No. 93-0470-LFO, 1993 WL 548830 (D.D.C. Dec. 22, 1993).

⁸ The district court in the *Guernsey* case had ruled in favor of the Secretary, but that decision was reversed by the Sixth Circuit.

As to section 233, the *Guernsey* court concluded that it was invalid. *Id.* at 835. This is because issuance of the Provider Reimbursement Manual was not preceded by the formal rulemaking requirements of 5 U.S.C. § 553⁹ and thus it does not carry the force and effect of law or regulation. *National Medical Enterprises v. Bowen*, 851 F.2d 291, 293 (9th Cir. 1988). Lacking these formal requisites, section 233 could only be valid if it were an "interpretive" rule as opposed to a "substantive" rule.¹⁰ See 5 U.S.C. § 553(b) (A).

Accordingly, the Secretary argued in *Guernsey*, as she argues herein, that section 233 merely interprets the regulations. The *Guernsey* court, however, disagreed. It found that as opposed to merely interpreting existing regulations, section 233 impermissibly changed the meaning of the properly promulgated regulations. *Id.* at 835; See also *Graham*, 832 F.Supp. at 1243. Hence, the *Guernsey* court found that section 233 worked a substantive change in the regulations and was thus an invalid attempt to make a substantive rule without the formalities of the Administrative Procedures Act.¹¹ *Guernsey*, 996 F.2d at 832.

⁹ These requirements include advance notice of the terms or substance of a proposed rule under § 553(b) and an opportunity for interested persons to comment through the submission of written data, views or argument under § 553(c).

¹⁰ Interpretive rules clarify or explain existing law or regulations; substantive rules grant rights, impose obligations or produce other significant effects on private interests. *American Hospital Association v. Bowen*, 834 F.2d 1037, 1045 (D.C.Cir. 1987).

¹¹ Also, the *Guernsey* court rejected the Secretary's attempted distinction between the Hospital's reporting of its

We agree with the reasoning of Guernsey and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities. Moreover, we see nothing contrary to this holding in our decision in *Sun Towers, Inc. v. Hecker*, 725 F.2d 315 (5th Cir.), cert. denied, 469 U.S. 823, 105 S.Ct. 100, 83 L.Ed.2d 45 (1984).

*4 In *Sun Towers*, this Court was called on to decide whether certain costs were allowable under the Medicare program. Among these costs were "stock maintenance

costs and the reimbursement for those costs. The Secretary argued that the regulations mandated the use of GAAP only for the Hospital's internal cost reporting and that § 233 was sufficient to establish a different accounting system for cost reimbursement. In rejecting this argument, the court noted that the purpose of cost reporting was to enable the Hospital's costs to be known so that reimbursement could be calculated. For that reason, the court felt that there should be a nexus between the fundamental principles of cost reporting and cost reimbursement. Accordingly, the Guernsey Court found that § 233 was ineffective because "[t]he 'nexus' that exists in the regulations between cost reporting and cost reimbursement is too strong . . . to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedures Act." *Id.* at 836. We agree with this statement.

costs."¹² *Id.* at 326. The Secretary disallowed reimbursement for these costs finding that they were only tangentially related to the care of Medicare beneficiaries.¹³ The district court, however, reversed the Secretary's determination.

Among the arguments the district court presented to support its decision in *Sun Towers* was an argument based on GAAP. *Id.* at 328. Under GAAP, stock maintenance costs are recognized as general and administrative expenses. Thus, the district court argued that these costs were allowable because 42 C.F.R. § 405.406¹⁴ required GAAP to be applied in determining reasonable costs. *Id.*

We rejected this argument holding that GAAP was not necessarily to be used in determining if a particular cost was allowable. *Id.* at 328-29. In particular, we found that section 405.406 was not designed to determine the "costs allowable under the Medicare Act. The regulation is directed at the type of financial data and reports required of providers; it is not a regulation affecting the substantive provisions of the program as to what constitutes reimbursable costs." *Id.* at 329 (quoting *American*

¹² These costs consisted of 1) stock transfer and registration fees; 2) reports to stockholders; 3) stockholders' meetings; 4) legal and accounting fees incurred through the SEC filings and stockholders' meetings; and 5) public relations aimed at institutional investors.

¹³ Medicare does not reimburse all expenses, but only those that are reasonably related to patient care. *Id.* at 328 n. 25; 42 U.S.C. § 1395x(v)(1)(A).

¹⁴ This section was the precursor to § 413.20.

Medical International, Inc. v. Secretary of Health, Education and Welfare, 466 F.Supp. 605, 623 (D.D.C.1979), aff'd 677 F.2d 118 (D.C.Cir.1981) (emphasis added). Hence, we reversed the decision of the district court and held that the Secretary's determination was neither arbitrary nor capricious. Sun Towers, 725 F.2d at 330.

In Sun Towers, the issue was whether a particular cost was allowable at all. In the case at bar, as it was in the Guernsey case, the issue is when a cost that was clearly allowable should have been reimbursed. These are different questions and we do not believe that Sun Towers speaks to the issue of when reimbursement is to be made.

Accordingly, we adhere to our decision in Sun Towers as to whether a particular cost is allowable. However, we follow Guernsey as to when advance refunding costs are to be reimbursed.

III.

CONCLUSION

For the reasons stated above, we hold that, under the applicable Medicare regulations, the Hospital was entitled to reimbursement for the full amount of its advance refunding loss in 1987 plus interest. Therefore, we REVERSE the decision of the district court and REMAND this case for a determination of the exact amount of the

advance refunding loss and the amount reimburseable under Medicare plus interest from 1987.¹⁵

¹⁵ The Hospital argues that we should hold that the fiscal intermediary's figure of \$11,671,393 is correct as to the amount of the advance refunding loss. However, this factual issue was not decided by the PRRB or the Secretary, it was not before the district court, and we do not address it. See Presbyterian Hospital of Dallas v. Harris, 638 F.2d 1381, 1389 (5th Cir.), cert. denied, 454 U.S. 940, 102 S.Ct. 476, 70 L.Ed.2d 248 (1981).

No. 93-1251

U.S. Supreme Court
FILED

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In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

*ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT*

REPLY BRIEF FOR THE PETITIONER

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R. Kay & D. Searfoss, <i>Handbook of Accounting and Auditing</i> (2d ed. 1989)	5
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In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-1251

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
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REPLY BRIEF FOR THE PETITIONER

1. Respondent attempts to defend the court of appeals' broad holding that the Secretary's regulations require application of generally accepted accounting principles (GAAP) to resolve every reimbursement issue, in the absence of a specific regulation to the contrary with respect to a particular issue. See Br. in Opp. 12-21. As we explain in the certiorari petition (Pet. 14-22), however, nothing in the text or background of the pertinent regulations supports that rule. The purpose of the reimbursement principles set forth in the Secretary's Provider Reimbursement Manual¹ (PRM) (including PRM Section 233, which addresses advance refunding transactions) is to

¹ United States Department of Health & Human Services, Health Care Financing Administration, Medicare Provider Reimbursement Manual (1987).

resolve reimbursement disputes arising under those long-standing regulations. The very existence of (and pervasive reliance on) the PRM in the day-to-day administration of the Medicare Program demonstrates the fallacy of respondent's and the court of appeals' view that the Secretary has effectively delegated to the accounting profession the power to prescribe and revise reimbursement principles, and thereby to dictate the outcome of reimbursement disputes under the massive and costly Medicare program.² See Pet. 15.

If the Secretary had intended that GAAP would trump even express provisions of the PRM, surely the regulations or the PRM itself would have said so. In fact, however, the foreword to the PRM states (at I) that GAAP should normally be applied in determining reimbursable costs *where the Secretary's guidelines and policies do not supply a contrary rule*. See also *American Medical Int'l, Inc. v. Secretary of HEW*, 466 F. Supp. 605, 624 n.21 (D.D.C. 1979). Moreover, the Commissioner of Social Security formally explained the operation of the regulatory scheme in this manner in 1976 when he promulgated certain reimbursement rules relating to equity capital, stating (41 Fed. Reg. 46,292 (emphasis added)):

[G]enerally accepted accounting principles are applicable to Medicare cost determinations only when a cost situation is not covered by 20 C.F.R. Part 405 [now 42 C.F.R. Part 413] or the *Provider Reimburse-*

² The Medicare regulations were promulgated before the accounting profession had adopted an exclusive GAAP standard for accounting for advance refunding transactions. See *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26 (APB 26) ¶¶ 4-10 (Accounting Principles Bd. 1972) (describing alternate methods in general use before adoption of exclusive method by APB 26). Respondent's thesis must therefore be that although the Secretary's method of accounting for such transactions was permissible under her regulations at the time they were issued, it ceased to be permissible at the moment the Accounting Principles Board promulgated APB 26. See Br. in Opp. 17 n.6.

ment Manual. It is only in the absence of health insurance program policy that generally accepted accounting principles should be followed.

That reasonable interpretation of the Secretary's own regulations is entitled to "controlling weight."³ See *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993).

2. In the alternative, respondent attempts to defend the court of appeals' decision by asserting that the longstanding regulatory scheme implementing the Medicare program distinguishes for present purposes between *whether* and *when* particular costs incurred by a provider will be reimbursed. In respondent's view, the regulations do not require use of GAAP in determining whether costs will be reimbursed, but generally do require use of GAAP with respect to timing. The regulations on which respondent relies draw no such distinction. They speak only of "[s]tandardized * * * accounting * * * and reporting practices," 42 C.F.R. 413.20(a), and of "the accrual basis of accounting," 42 C.F.R. 413.24(a). If, as respondent claims, those regulations require the Secretary to apply GAAP in determining Medicare reimbursements, they provide no basis for her to distinguish, in doing so, between "characterization" and "timing" issues.

Moreover, even a proper cost of care is "allowable" under Medicare only with respect to the particular period

³ Respondent cites (Br. in Opp. 18) a court's passing characterization of the Secretary's position in *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 (9th Cir. 1989), for the proposition that the Secretary has switched her position depending on which interpretation of the regulations helped her cause in particular litigation. That is incorrect. The Secretary has never disputed that GAAP provides standard accounting rules that may be useful in determining proper Medicare reimbursement (as well as for general recordkeeping and financial reporting purposes) where the regulations and the PRM do not prescribe a particular rule. So far as we are aware, however, the Secretary has never taken the position that her regulations require application of GAAP for reimbursement purposes where, as here, she has prescribed a contrary interpretation. We have reviewed the government's brief in *HCA*, and it is fully consistent with that position.

in which the provider rendered the care to which the cost relates; and the determination of *when* a cost relates to the provision of patient care is as fundamental as the determination of whether it relates to patient care at all.⁴ See generally 42 C.F.R. 413.9 (cost determination); 413.24(d) and (f), 413.50, 413.53 (apportionment); 413.60(b), 413.64(b) (estimated and final payments); see also *Research Medical Center v. Schweiker*, 684 F.2d 599, 603 (8th Cir. 1982) (deferring to PRM capitalization requirement for interest on construction loans because spreading costs over several years best reflects benefit of constructed facility to Medicare beneficiaries). Medicare reimbursement is made on an annual basis, following review of the provider's annual cost report. See *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. 2151, 2157 (1993); *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399, 400-401 (1988). It is based on "the actual cost of services furnished to beneficiaries during the year." 42 C.F.R. 413.9(b) (emphasis added). Accordingly, the central issue in reviewing a provider's report is what costs may properly be reimbursed by Medicare for that cost year. The reason why costs might not be reimbursable for the particular cost year has no bearing on whether the Secretary is obligated to look outside her own policy directives under the Medicare Program—to GAAP—in order to resolve that issue.

3. Respondent repeatedly refers to "the accrual basis of accounting" as though that term were synonymous with GAAP. See, e.g., Br. in Opp. 14, 16, 20-21. It is not. Both as a matter of normal usage and as defined in the relevant regulation itself, accrual accounting describes any system under which "revenue is reported in the period when it is

⁴ Indeed, as pointed out in the petition, the apportionment of a provider's otherwise allowable costs between Medicare and non-Medicare patients may vary substantially from period to period (because, for example, of fluctuations in the provider's patient mix). Shifting such costs between periods may therefore have an equally substantial effect on the amount that is actually reimbursable under Medicare. See Pet. 21, 26 n.15.

earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." 42 C.F.R. 413.24(b)(2). That definition is broad, and excludes primarily "cash-basis" accounting, under which revenues are reported when collected, and expenses when paid.

Respondent's bald assertion that "[t]here are no 'versions' of accrual accounting" (Br. in Opp. 17) is simply wrong. "Cost" or "management" accounting, for example—that is, accounting that is designed to provide current and often specialized financial information for management purposes—is generally based on accrual principles, but is not governed by GAAP. See generally D. Keller, J. Bulloch & R. Shultis, *Management Accountants' Handbook* 1.2-1.3 (4th ed. 1992). Accrual (not cash-basis, compare Br. in Opp. 20-21) accounting for state and local governments and their proprietary activities may be governed by the standards of the Governmental Accounting Standards Board (GASB), which differs from the GAAP applicable to private entities—but which in fact constitutes "GAAP" for those entities to which it applies.⁵ See generally R. Kay & D. Searfoss, *Handbook of Accounting and Auditing* 31-4 to 31-10 (2d ed. 1989); M. Dittenhofer, *Applying Government Accounting Principles* § 1.03[2] (1990) ("only the standards promulgated by the GASB have the status of GAAP for state and local governments"); *id.* at §§ 9.03-9.04 (discussing "accrual" and "modified accrual" accounting); A. Afterman & R. Jones, *Governmental Accounting and Auditing Disclosure Manual* § 1 (1992). And in areas where a particular GAAP standard has not been established, or where GAAP recognizes more than one approach, a variety of quite different approaches may be recognized as legitimate

⁵ As noted in the petition (at 18 n.11), the GASB's Statement of Governmental Accounting Standards No. 23 requires covered entities to report gains and losses on advance refunding transactions on a deferred basis very similar to that required by the Secretary for purposes of Medicare reimbursement.

methods of accrual-basis accounting. See, *e.g.*, APB 26, ¶¶ 4-10; see also note 2, *supra*. Thus, even if the regulations' requirement that providers keep financial data "on the accrual basis of accounting" (42 C.F.R. 413.24(a)) were interpreted to constrain the Secretary's discretion in making use of those data in determining appropriate Medicare reimbursements, it could not be read to require her to defer specifically to GAAP in making those determinations.⁶

4. Respondent argues (Br. in Opp. 17-18) that the "cost finding" provisions of 42 C.F.R. 413.24 demonstrate that the same Section's references to "the accrual basis of accounting" apply to the Secretary's reimbursement determinations, rather than simply to the way in which a provider's records must be maintained. The "cost finding" required by the regulations refers to the process of apportioning general and indirect costs (such as many administrative costs) to recognized cost centers for purposes of Medicare reimbursement. See generally 42 C.F.R. 413.24(d). That process merely requires the provider to reorganize some of its normal financial data in a way specifically designed to help identify which of its costs for the relevant period—all of which are presumably

⁶ Respondent's defense of the court of appeals' holding that PRM Section 233, which prescribes non-GAAP treatment for advance refunding gains and losses, is a "substantive" rather than an "interpretative" rule (Br. in Opp. 21-24) makes clear that the argument rests entirely on the proposition that the Medicare regulations require application of GAAP in the absence of a specific statute or regulation to the contrary. Respondent's argument (Br. in Opp. 24) based on 42 U.S.C. 1395hh(a)(2) rests on the same proposition—that PRM Section 233 "changes a substantive legal standard governing * * * the payment for services," because (in respondent's view) the general regulations "establish, as a baseline, that reimbursement determinations will be made in accordance with GAAP. Both arguments thus depend in turn on the equation that respondent posits between GAAP and "the accrual basis of accounting" within the meaning of 42 C.F.R. 413.24(a). See, *e.g.*, Br. in Opp. 21, 23. As discussed above and in the petition, however, that equation is fallacious.

legitimate under GAAP—are allowable under the special standards of the Medicare program. If the requirement that providers "recast" their basic financial data in that way in preparing their Medicare cost reports has any larger significance, it is to refute respondent's simplistic assertion (Br. in Opp. 15) that Section 413.20(a) of the regulations somehow guarantees that in order to be entitled to reimbursement, providers need do no more than present the Secretary with their "basic accounts, as usually maintained."⁷

5. a. The court of appeals' erroneous ruling warrants review by this Court. In attempting to distinguish the conflicting cases cited in the petition (Pet. 11-14), respondent contends that those decisions "address whether or not a certain type of cost is allowable" (Br. in Opp. 9), and accuses the Secretary of "confus[ing] the issue of cost allowability with the issue of the timing of reimbursement for allowable costs." *Id.* at 8. It is of course true that in

⁷ Respondent also notes (Br. in Opp. 14) that the certiorari petition does not discuss 42 C.F.R. 413.5(b)(1). The court below did not cite that Section in support of its holding, and it is without relevance. Section 413.5(b)(1) states a general principle of current payment for expenses as they are incurred, which is implemented by specific interim payment and retroactive adjustment provisions. See 42 C.F.R. 413.60, 413.64; *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. at 2155-2156. It has nothing to do with determining when expenses are incurred (a central question of accrual accounting), so that "current payment" becomes appropriate. Indeed, read in isolation, the "current payment" language would suggest a rule of cash-basis reimbursement—that is, payment shortly after the provider is forced to "put up money for the purchase of goods and services." 42 C.F.R. 413.5(b)(1). As respondent itself points out, however, the cash outlays relevant to this case took place primarily in 1972 and 1982. Br. in Opp. 4. Respondent and the Secretary agree that Medicare reimbursement with respect to those cash expenditures is appropriately spread out over many years after they took place. The only question at the time of refunding is whether the original costs that remain unrecovered (as well as certain costs of the refunding itself) should continue to be recognized on the original schedule, or be accelerated into the year of the refunding. Section 413.5(b)(1) provides no guidance on that question.

most advance refunding cases, including this one, there is no dispute as to the overall refunding loss (or gain) realized by a Medicare provider; the question is, instead, in which accounting period or periods that loss should be taken into account (or "allowed") for purposes of Medicare reimbursement. See Pet. 25. As we have just explained (see pages 3-5, *supra*), however, there is no relevant distinction between that question of "timing" and the question of "reimbursability *vel non*" (Br. in Opp. 10 (citation omitted)). Both are aspects of the same question presented by this case: whether the Secretary's regulations require that a provider's costs be reimbursed in all respects—including timing—in accordance with GAAP.

In any event, respondent's attempt to deny the existence of a circuit conflict on the basis of its timing/allowability distinction is unconvincing. To begin with, there was no dispute in *Methodist Hospital of Indiana, Inc. v. United States*, 626 F.2d 823 (Ct. Cl. 1980) (see Br. in Opp. 9) that the pension costs at issue in that case were both (i) reimbursable if properly accrued and (ii) properly accrued for purposes of the provider's financial accounting. 626 F.2d at 824, 826. The decision stands cleanly for the proposition that the Secretary need not defer to a financial accounting determination of the proper *timing* of an otherwise reimbursable cost.

Similarly, the issue in *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130 (D.C. Cir. 1982), was whether a stock purchase should be treated as a purchase of assets for Medicare purposes, thus allowing the purchaser to allocate the stock price to the assets and recover it over time through increased depreciation. Although the court disposed of the case on other grounds, it made clear that even if the transaction were properly characterized as an asset acquisition for accounting purposes, that would not determine the proper Medicare treatment. *Id.* at 135. And the issue of accounting or reimbursement "symmetry" on

which that conclusion turned was as much one of "timing" as one of "reimbursability *vel non*."⁸

To be sure, some cases holding that GAAP does not automatically govern the Secretary's reimbursement decisions deal with issues of characterization, rather than timing. The courts in *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542, 547 (9th Cir. 1990), cert. denied, 500 U.S. 917 (1991), and *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 328-329 (5th Cir.), cert. denied, 469 U.S. 823 (1984), rejected the contention that because "stock maintenance" costs were recognized as legitimate administrative expenses under GAAP, the Secretary was required to treat them as reimbursable costs of patient care. As explained above, however, the regulations on which respondent relies draw no distinction between "characterization" and "timing" issues, and that distinction therefore cannot detract from the conflict that exists over whether the regulations require the use of GAAP in resolving reimbursement questions.⁹

⁸ As the court explained, allowing the buyer's accounting treatment to dictate reimbursement would "destroy the symmetry of the regulatory scheme" by allowing increased depreciation deductions to the buyer in years after the purchase, without a corresponding recapture, in the year of the sale, of depreciation deductions previously taken by the seller. 684 F.2d at 135. The fundamental point is to allow only one reimbursement for the original cost of the assets, either by denying duplicative depreciation deductions (and corresponding cost reimbursements) to the buyer, or by balancing such future deductions (and reimbursements) against a lump-sum recapture amount recognized as income to the seller in the year of the sale. Either system must be followed with respect to both buyer and seller in order to achieve proper overall timing of depreciation reimbursements for the acquired assets. The court indicated that it would defer to the Secretary's resolution of that "timing" issue for Medicare reimbursement purposes, without regard to the accounting treatment adopted by either party to the transaction. *Ibid.* & n.5.

⁹ A panel of the Fifth Circuit recently accepted the distinction of *Sun Towers* proposed by respondent in this case, and reversed a decision in favor of the Secretary on the advance refunding issue. *Mother Frances Hosp. v. Shalala*, No. 93-4388 (5th Cir. Mar. 3, 1994),

b. Respondent does not seriously attempt to refute our submission (Pet. 24-27) that this case presents an issue of substantial practical and legal importance. Indeed, respondent concedes (Br. in Opp. 25) that the petition "conclusively demonstrates" the importance of the issue to providers—and, by the same token, to the Secretary. Beyond that concession, respondent merely restates the premise that Section 233 of the PRM works a substantive change in reimbursement rules established by the general Medicare regulations, and on that basis argues that the decision below is unremarkable in requiring compliance with the notice-and-comment requirements of the Administrative Procedure Act. Br. in Opp. 25-26. It is precisely by adopting that false premise, however, that the court of appeals has threatened both normal principles of deference to the Secretary's interpretation of her own regulations implementing a complex benefits program, and the imposition of substantial unjustified monetary liability on the federal government. As set forth in the petition, those threats warrant review by this Court, especially in view of the continuing circuit conflict on the basic question presented.

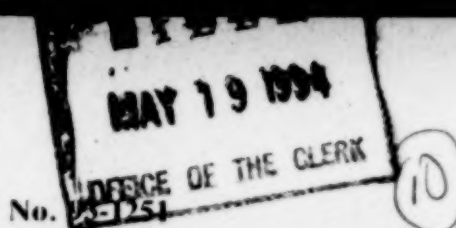
For the foregoing reasons and those stated in the petition, the petition for a writ of certiorari should be granted.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

MARCH 1994

slip op. 2838-2839; compare Pet. 14 n.9. We obviously disagree with the panel's reading of *Sun Towers*, as well as with its decision on the merits. We also note that respondent's reliance (Br. in Opp. 10-11, 16) on decisions of the Provider Reimbursement Review Board is misplaced. Each of the Board's advance refunding decisions has been reversed by the Secretary's designate; and it is the Secretary, not the Board, to whose expertise deference is due. *E.g.*, *Sun Towers*, 725 F.2d at 326; *St. Francis Hosp. Ctr. v. Heckler*, 714 F.2d 872, 874 (7th Cir. 1983); cf. *Martin v. OSHRC*, 499 U.S. 144, 152-153 (1991).



In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND
HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL, RESPONDENT

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JOINT APPENDIX

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Petition for Certiorari Filed February 1, 1994
Certiorari Granted April 4, 1994

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RELEVANT DOCKET ENTRIES

United States District Court

11/1/90 Complaint filed.
 1/30/91 Answer filed.
 3/15/91 Motion by respondent for summary judgment filed.
 4/23/91 Motion by petitioner for summary judgment filed.
 3/30/92 Memorandum, Opinion and Order, granting petitioner's motion for summary judgment (filed 4/23/91), denying respondent's motion for summary judgment (filed 3/15/91), and dismissing case.
 3/30/92 Judgment.
 5/26/92 Notice of appeal by respondent filed.

United States Court of Appeals For The Sixth Circuit

3/2/93 Oral argument held.
 6/18/93 Opinion reversing judgment of the District Court issued; judgment entered.
 10/4/93 Order denying the petition for rehearing with suggestion of rehearing *in banc*.

United States Supreme Court

12/28/93 Order by Justice Stevens extending the time for filing a petition for a writ of certiorari to 2/1/94.
 2/1/94 Petition for a writ of certiorari filed.
 3/3/94 Brief for respondent in opposition filed.
 3/8/94 Supplementary Brief for respondent in opposition filed.

3/21/94 Reply Brief for petitioner filed.
 4/4/94 Petition for certiorari granted.

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September 20, 1990

VIA FEDERAL EXPRESS

Anthony J. Tirone, Director
 Office of the Attorney Advisor
 Health Care Finance Administration
 669 East High Rise
 6325 Security Boulevard
 Baltimore, MD 21207

Re: Guernsey Memorial Hospital
 PRRB Case No. 88-1092
 PRRB Decision No. 90-D50

Dear Mr. Tirone:

The Provider, Guernsey Memorial Hospital, hereby responds to the comments of the Bureau of Policy Development which were recently submitted in the above-referenced matter. The Provider received these comments on September 19, 1990.

First, in regard to the advance refunding issue, the Bureau refers this Administrator to comments the Bureau previously submitted in *Mercy Hospital v. Blue Cross and Blue Shield Assoc.*, PRRB Decision No. 89-D65 and *Baptist Hospitals Group v. Blue Cross and Blue Shield Assoc.*,

PRRB Decision No. 89-D65. The Bureau's comments in *Mercy and Baptist* were repudiated by the Board's decision in this case. In addition, the Bureau's arguments have already been rebutted in the Provider's initial comments submitted herein on September 14, 1990 and in the Provider's position paper and post-hearing brief.

Second, on page two of its comments, the Bureau discusses a series of meetings and discussions which allegedly occurred regarding the adoption of PRM Section 233. There is no evidence of any of these meetings or discussions in the record of this case. If the Intermediary believed that the content of these alleged meetings and discussions was important to this matter, it could have offered the same as evidence at the hearing before the Provider Reimbursement Review Board. The Intermediary did not do so. As such, 42 C.F.R. Section 405.1875(e)(2) expressly forbids the Bureau from referring in its comments to the alleged meetings and discussions. Such regulation states as follows regarding submissions to this Administrator: "[t]hese submissions shall be limited to issues the Administrator has decided to review *and confined to the record of the Board hearing.*" (emphasis added). Pursuant to Section 405.1875, this Administrator cannot properly consider the representations contained on page two of the Bureau's comments since they are external to the record in this case.

Finally, the Bureau, in reference to the debt service fund issue, cites a decision which actually supports the Board's action in this case. In *Good Samaritan Hospital v. Blue Cross Assoc./Mutual Hospital Insurance, Inc.*, PRRB Decision No. 79-D80 (Nov. 26, 1979), *aff'd* HCFA Admin. Decision (Jan. 23, 1980), the Bureau similarly argued that a bond restricted fund designated to pay principal and interest was not funded depreciation. The Deputy Administrator disagreed with the Bureau's position and asserted:

"[t]he Deputy Administrator does not agree with the comment that the lease rental reserve fund does not qualify as a funded depreciation account because it is partially designated for payment of interest on the bonds." The Deputy Administrator went on to affirm the Board's reversal of the Intermediary, finding that the provider's allowable interest expense was not properly offset with income earned on the bond restricted fund.

The decision in *Good Samaritan* is consistent with the ruling the Board cited in its decision in this case. In both *Good Samaritan* and *General Hospital of Everett v. Blue Cross and Blue Shield Assoc.*, PRRB Decision No. 88-D14 (Jan. 15, 1988), the Board held that interest income earned from a bond restricted fund, such as the debt service fund at issue herein, cannot be offset against a provider's allowable interest expense.

For the foregoing reasons, and those set forth in the Provider's initial comments, post-hearing brief and position paper already filed in this matter, the Provider respectfully requests that this Administrator affirm the decision of the Board.

Sincerely,

/s/ Scott Taebel

SCOTT W. TAEBEL

SWT/kjm

copy: Bernard M. Talbert

Kathleen A. Buto

a2920

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

MEMORANDUM

Date: Sep. 17, 1990

From: Director, Bureau of Policy Development

Subject: Guernsey Memorial Hospital Appeal, Provider
Reimbursement Review Board (PRRB) Decision No.
90-D50—INFORMATION

To: Director, Office of the Attorney Advisor

The Bureau of Policy Development believes the subject case was wrongly decided with respect to both issues and that the PRRB's decision should be reversed.

Regarding issue number one involving the treatment of an advance refunding of debt, the facts are reasonably straightforward. The provider incurred a loss on the advance refunding of certain debt. There was no dispute regarding the reasonableness of the advance refunding, nor whether it was related to patient care. The sole dispute was the proper handling of the loss incurred by the provider on the advance refunding. The fiscal intermediary properly applied section 233 of the Provider Reimbursement Manual (PRM). PRM section 233 does not *explicitly* recognize a gain or loss on an advance refunding. Rather, the policy set forth therein calls for recognition of the constituent elements of income and expense associated with the advance refunding in such a manner that any gain or loss incurred is *implicitly* recognized from the date the advance refunding occurs to the date the holders of the refunded debt receive the principal payment. The PRRB rejected the clear policy expressed in PRM section 233 in favor of immediate recognition of the loss as required under generally accepted accounting principles (GAAP).

We direct your attention to our comments regarding PRRB Decision Nos. 89-D64 and 89-D65 sent to your office by memorandum dated October 13, 1989 (copy attached). Although the transactions involved in those PRRB decisions predated the effective date of Provider Reimbursement Manual section 233, we believe that our objections to the immediate recognition of a gain or loss on an advance refunding expressed in that memorandum are also applicable to the instant case. Rather than to repeat those objections here, we will incorporate them by reference.

Because this case involves an advance refunding transaction initiated after the effective date of PRM section 233, and in light of the decision in the case of *Charlotte Memorial Hospital and Medical Center, Inc. v. Bowen*, No. 87-3745 (CA-4 September 1988) (*Charlotte*), we believe some additional comment is necessary. In *Charlotte*, the court held that the Secretary would be at the very limit of his authority in prescribing regulatory interpretations that conflict with GAAP and that such interpretations would be subject to greater scrutiny than interpretations that are consistent with GAAP. We believe that a review of the historical development of the policy expressed in PRM section 233 will show that this policy was cultivated with extraordinary public consultation. To wit, in late 1981, we were in the process of preparing a version of proposed new PRM section 233 which would have precisely followed the approach set forth in GAAP for recognizing gains and losses associated with the advance refunding of debt. Before final publication of the PRM revision, we withdrew the proposal based on overwhelming objections from the provider community. To resolve these objections, we met with representatives from the Blue Cross and Blue Shield Association, the Health Care Financial

Management Association, the American Institute of Certified Public Accounts (the recognized authority with respect to GAAP pronouncements), the American Hospital Association, the Catholic Health Association of the United States, the Federation of American Hospitals, and the public accounting firm of Ernst & Whinney (now Ernst & Young). In addition, we received written and/or oral comments from the law firm of Weissburg and Aronson and the Health Care Financing Study Group (investment counselors). Based on this most intensive and intimate prior consultation, the overwhelming majority opinion was to adopt the policy that is currently expressed in PRM section 233. (Only the Federation of American Hospitals continued to believe that the GAAP approach should prevail.) The substance of the majority opinion, with which we agreed, was that the broad, underlying accounting principle that dictated the immediate recognition of gains and losses on advance refundings was the principle of conservatism. The majority consultees felt that, for Medicare reimbursement purposes, such an approach would cause distortions and a mismatching of expenses with the periods benefitted. The majority felt that the broad, underlying accounting principle of matching expenses with the periods benefitted was a much more appropriate principle upon which to base Medicare reimbursement. Thus, we believe the current version of PRM section 233, which has undergone a most intensive prior consultation, not only effects the payment of reasonable costs associated with advance refundings, but also would pass muster under the closer scrutiny test expressed in *Charlotte*.

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Writer's Direct Dial Number

October 10, 1989

Guernsey Memorial Hospital
1241 North Clark Street
Cambridge, Ohio 43725

Re: \$15,375,000 City of Cambridge, Ohio
Hospital Improvement Revenue Refunding
Bonds, Series 1985
(Guernsey Memorial Hospital Project)

Dear Sirs:

You have requested us to advise you as to the liability of Guernsey Memorial Hospital (the "Hospital") concerning \$7,600,000 Hospital Improvement First Mortgage Revenue Bonds which the City of Cambridge, Ohio (the "City") issued on January 1, 1972 (the "1972 Bonds") and \$10,410,000 Hospital Improvement Revenue Bonds, Series 1982 which the City issued on October 1, 1982 (the "1982 Bonds"), following the issuance of the above-referenced refunding issue.

In this regard, we have examined the following:

(i) Copies of the Indenture of Mortgage, dated as of January 1, 1972, as supplemented by the Supplemental Indenture of Mortgage, dated as of October 1, 1982 (collectively, the "Prior Indenture") each between the City and BancOhio National Bank (the "Trustee");

(ii) Copies of the Lease, as supplemented by the Supplemental Lease, dated as of October 1, 1982, each dated as of January 1, 1972, between the City and the Hospital;

(iii) A copy of the Trust Indenture, dated as of February 1, 1985, between the City and the Trustee;

(iv) A copy of the Lease, dated February 1, 1985, between the City and the Hospital and the Memorandum of Assignment of Lease, of the same date, from the City to the Trustee;

(v) A copy of the Termination of Lease and Supplemental Lease, Release and Discharge of Indenture of Mortgage and Supplemental Indenture of Mortgage and Release of Guaranty, dated as of February 27, 1985, executed by the City, the Trustee and the Hospital;

(vi) A copy of the Escrow Agreement, dated as of February 1, 1985, among the City, the Trustee and the Hospital;

(vii) A copy of the Subscription for Purchase and Issue of U.S. Treasury Securities State and Local Government Series, filed with the Federal Reserve Bank of Cleveland on February 7, 1985;

(viii) A copy of the Verification Report of Ernst & Whinney, dated as of February 27, 1985; and

(ix) A copy of the opinion of Squire, Sanders & Dempsey, as Bond Counsel, dated as of February 27,

1985, relating to compliance with the conditions to defeasance of the 1972 Bonds and 1982 Bonds; a copy of which is attached to this letter.

Please be advised, however, that we have not assumed any responsibility for making any independent investigation or verification of any factual matter stated in or represented by any of the foregoing documents or any other factual matter. We further have assumed the conformity to originals of all copies of documents submitted to us and the authenticity of all signatures thereon of, the due execution and delivery pursuant to due authorization thereof by, and the validity and binding effect thereof on, each person other than the Hospital which is a party thereto.

Based upon and subject to the foregoing, we advise you that the 1972 Bonds and the 1982 Bonds have been deemed paid and discharged within the meaning of the Prior Indenture, and the Hospital has been released and discharged from any further obligation to pay debt service on the 1972 Bonds and 1982 Bonds.

This letter is intended for the information solely of the party to whom it is addressed, and no one other than such party is entitled to rely on this letter. Such limitation does not apply to the Provider Reimbursement Review Board for the purposes of its determination concerning the Hospital's Medicare appeal for the 1985 cost reporting period.

Very truly yours,

BRICKER & ECKLER

By: /s/ Randall E. Moore

A Partner

Return of Organization Exempt from Income Tax

Under section 501(c) (except black lung benefit trust or private foundation)
of the Internal Revenue Code or section 4947(a)(1) trust

Note: You may be required to use a copy of this return to satisfy State reporting requirements. See instruction D.

1995

For the calendar year 1985, or fiscal year beginning 1985, and ending 19

Use IRS label. Other-wise, please print or type.	Name of organization BO 31-4391798 990 GUERNSEY MEMORIAL HOSPITAL 1341 N CLARK ST CAMBRIDGE OH 43725	Employer identification number (see instruction L) 31: 4391798	State registration number (see instruction D) 43725
--	--	---	--

D Check type of organization—Exempt under section 501(c)(3) (insert number), OR 501(c)(1) trust exemption for section 4947(a)(1) trust exemption is pending

E Accounting method: ☐ Cash ☒ Accrual ☐ Other (specify)

F Section 4947(a)(1) trusts filing this form in lieu of Form 1041, check here ☐ (see instruction C10).
G Is this a group return (see instruction J) filed for affiliates? ☐ Yes ☒ No
Is this a separate return filed by a group affiliate? ☐ Yes ☒ No (GEN) ▶

☐ Check here if your gross receipts are normally not more than \$25,000 (see instruction B11). You do not have to file a completed return with IRS but should file a return without financial data if you were mailed a Form 990 Package (see instruction A). Some States may require a completed return.
☐ Check here if gross receipts are normally more than \$25,000 and line 12 is \$25,000 or less. Complete Parts I (except lines 13-15), III, IV, VI, and VII and only the indicated items in Parts II and V (see instruction I). If line 12 is more than \$25,000, complete the entire return.

501(c)(3) organizations and 4947(a)(1) trusts must also complete and attach Schedule A (Form 990). (See instructions.)

Part I Statement of Support, Revenue, and Expenses and Changes in Fund Balances		(A) Total	(B) Unrestricted/Expendable	(C) Restricted/Nonexpendable
1 Contributions, gifts, grants, and similar amounts received:				
a	Direct public support	72,361.		
b	Indirect public support			
c	Government grants			
d	Total (add lines 1a through 1c) (attach schedule—see instructions)	72,361.		
2	Program service revenue (from Part IV, line f)	26,810.139.		
3	Membership dues and assessments	- 0 -		
4	Interest on savings and temporary cash investments	75,722.		
5	Dividends and interest from securities	317,641.		
6a	Gross rents			
b	Minus: rental expenses			
c	Net rental income (loss)	- 0 -		
7	Other investment income (Describe: Funds Held by Trustees)	244,681.		
8a	Gross amount from sale of assets other than inventory			
b	Minus: cost or other basis and sales expenses			
c	Gain (loss) (attach schedule)	- 0 -		
9	Special fundraising events and activities (attach schedule—see instructions):			
a	Gross revenue (not including \$ of contributions reported on line 1a)			
b	Minus: direct expenses			
c	Net income (line 9a minus line 9b)	- 0 -		
10a	Gross sales minus returns and allowances			
b	Minus: cost of goods sold (attach schedule)			
c	Gross profit (loss)	- 0 -		
11	Other revenue (from Part IV, line g)	213,784.		
12	Total revenue (add lines 1d, 2, 3, 4, 5, 6c, 7, 8c, 9c, 10c, and 11)	27,734,328.		
13	Program services (from line 44, column (B)) (see instructions)	25,809,269.		
14	Management and general (from line 44, column (C)) (see instructions)	1,509,355.		
15	Fundraising (from line 44, column (D)) (see instructions)	- 0 -		
16	Payments to affiliates (attach schedule—see instructions)	- 0 -		
17	Total expenses (add lines 16 and 44, column (A))	27,318,624.		
18	Excess (deficit) for the year (subtract line 17 from line 12)	415,704.		
19	Fund balances or net worth at beginning of year (from line 74, column (A))	10,144,546.		
20	Other changes in fund balances or net worth (attach schedule)			

All organizations must complete column (A). Columns (B), (C), and (D) are required for trust section 501(c)(3) and (C)(4) organizations and 4947(e)(1) trusts but optional for others. (See instructions.)

Do not include amounts reported on lines 6b, 8b, 9b, 10b, or 16 of Part I.	(A) Total	(B) Program services	(C) Management and general	(D) Fundraising
22 Grants and allocations (attach schedule)	- 0 -	- 0 -		
23 Specific assistance to individuals	- 0 -	- 0 -		
24 Benefits paid to or for members	- 0 -	- 0 -		
25 Compensation of officers, directors, etc.	283,896.	44,315.	239,581.	
26 Other salaries and wages	8,523,329.	8,286,465.	236,864.	
27 Pension plan contributions	419,264.	396,624.	22,640.	
28 Other employee benefits	561,476.	531,156.	30,320.	
29 Payroll taxes	650,061.	614,958.	35,103.	
30 Professional fundraising fees	- 0 -			
31 Accounting fees	116,009.	- 0 -	116,009.	
32 Legal fees	50,454.	- 0 -	50,454.	
33 Supplies	431,129.	431,129.	- 0 -	
34 Telephone	119,700.	119,700.	- 0 -	
35 Postage and shipping	35,712.	17,856.	17,856.	
36 Occupancy	- 0 -	- 0 -	- 0 -	
37 Equipment rental and maintenance	832,253.	803,707.	28,546.	
38 Printing and publications	31,819.	- 0 -	31,819.	
39 Travel	27,582.	- 0 -	27,582.	
40 Conferences, conventions and meetings	- 0 -	- 0 -	- 0 -	
41 Interest	1,659,200.	1,659,200.	- 0 -	
42 Depreciation, depletion, etc. (attach schedule)	1,494,771.	1,494,771.	- 0 -	
43 Other expenses (itemize): a				
b See attached schedule	11,409,388.	11,409,388.	- 0 -	
c Extraordinary item - loss on				
d debt extinguishment	672,581.	- 0 -	672,581.	
e				
f				
44 Total functional expenses (add lines 22 through 43)	27,318,624.	25,809,269.	1,509,355.	- 0 -

List each program service title on lines a through d; for each, identify the service output(s) or product(s) and report the quantity provided. Enter the total expenses attributable to each program service and the amount of grants and allocations included in that total. (See instructions for Part III.)

Exhibits
(Continued on page 11)
11/11/1991

	(Grants and allocations \$)	25,809,269.
b	(Grants and allocations \$)	
c	(Grants and allocations \$)	
d	(Grants and allocations \$)	
e	Other program service activities (attach schedule)	
	(Grants and allocations \$)	

[PRRB HEARING HUELSKAMP TESTIMONY]

* * * * *

[189] Q. Now who benefits from that type of a savings, Mr. Huelskamp?

A. The hospital benefits from that due to the reduced cash flow that we have to extend over a period of time. The patients of Guernsey Memorial Hospital [190] populous of the county benefit in a reduction of our hospital charges because we don't have to charge as much to cover those additional interest costs, the Medicare program, Medicaid program and other payers benefit from the standpoint of the reduced interest cost is not there to reimburse the hospital. So there is a reduction in their reimbursement to the Providers.

* * * * *

[194] A. Subsequent to the year 1985, the debt, the 1972 debt, the 1972 and '82 bond issues are not carried on the hospital's financial records at all nor are they included in the footnotes. In our 1985 financial statements—

Q. Is that Provider Exhibit 28?

A. Provider Exhibit Number 28 is the hospital's audited 1985 financial statements. And on those financial statements the balance sheet effect of the refunding is to remove the 1972 and '82 debt from our books and put the '85 bonds issue that year on the financial statements. On the income statement we show the loss on the debt extinguishment that was the item in question and on the statement of changes and financial position we see the old debt being removed and the new debt being placed onto the hospital's financial statements.

And as I said before in subsequent years after 1985, the '72 and the '82 issues are no longer presented on the financial statements.

Q. Are they footnoted anywhere in the financial statements after 1985?

A. No, they are not.

* * * * *

[196] Q. What were the components of the loss on the refinancing?

A. As Mr. Talbert had indicated in his opening statement and as indicated in the Intermediary's supplemental position paper, there are three components to the loss. The first component of approximately \$700,000 is the write off of the unamortized bond discount and bond financing costs from the '72 and '82 bond issues.

Q. Okay, let's stop you there and ask you, can you go into a little bit more detail, what exactly are the unamortized costs? What are we talking about?

A. Those costs include the discount to the [197] underwriter for underwriting the '72 and the '82 issue, it would include bond counsel fees, legal fees, accountants fees, feasibility study fees, all of those costs related to the issuance of the '72 and the '82 bonds, those costs are prescribed by generally accepted accounting principles were amortized over the life of those respective costs.

Q. Now when were those costs actually paid?

A. Those costs were actually paid by the facility in 1972 and in 1982 as relate to those specific issues.

Q. So none of those are future costs, those are all past costs that the hospital incurred?

A. Those are past cash outlays that the hospital made at that point.

Q. What were the other components of the—

A. The second component of the composition of the loss that was taken is approximately \$300,000 and that relates to the call premium for the 1982 bond issue. That call premium is to be exercised in 1992 under the original

1982 bond issue, the hospital had to fund approximately \$300,000 to have funds sufficient to meet that call premium in 1992.

* * * * *

[199] THE WITNESS: The funds that were put into escrow to pay off the '72 and the '82 bond issues which was approximately \$16 million placed into escrow, those funds earn interest over a period of time until all the '72 and '82 bonds are paid off. The interest earned on that escrow fund exceeds the interest expense paid on the '72 and '82 bond by approximately \$300,000 and that in essence is a gain to the Provider which is netted against the two losses, the first and second components that I mentioned. Does that answer your question?

* * * * *

[201] Q. How does your treatment of this loss compare to the treatment that you would accord to other types of losses, for example sales depreciable asset?

A. In essence the accounting treatment is the same. If we had a depreciable asset on our books, let's say that we were depreciating over its estimated useful life, if we disposed of that asset prior to it being fully depreciated and would recognize a loss on that asset, that loss would be recognized all in the year of disposal of the asset rather than taking that loss and spreading it over the remaining usable life of what we had thought that asset would provide. This transaction is basically the same in that when the '72, the '82 bonds were originally put on the books, the bond financing and bond discount costs were being amortized over the life of the bonds. Now that those bonds no longer exist to the Provider, it is appropriate to take the remaining cost as an expense in the year that the bonds are retired.

* * * * *

[205] Q. Let me ask the question. If the total savings comparing the '85 bonds to the '72 and '82 bonds is \$12,367,000, is it true that approximately \$12 million of that savings will be realized in the year 2004 and later?

A. Yes.

* * * * *

[255] A. That's correct. Paragraph 3D is where the debtor is legally released from being the primary obligor under the debt which is the situation that we have incurred in the Guernsey Memorial Hospital situation.

* * * * *

[LANGENFIELD TESTIMONY]

[260] Q. Applying that analogy to the bond issues, how do they—taking the knowledge of the CT scanner, how does that affect the losses of the first bond issue which are the subject of the '72 and '82 bond issues?

A. I think they're very much the same. In 1985, in our situation here the Provider incurred a loss relating to the 1972 and 1982 bond issues and in looking at that transaction in essence, the hospital incurred interest costs over the past period of time from 1972 to 1985. And it estimated a usable life for 1972 issue costs and the 1982 issue costs based upon the originally intended maturity of those bonds. In reality in 1985 the hospital relieved itself of any obligation of the 1972 and 1982 bonds and recognized a loss to their—I don't want to belabor too much the components but various components, all of which relate to the 1972 and 1982 bonds and at least in theory and to certain extent in practice I believe the debtor, in this case the hospital, had it known it was going to relieve itself of those obligations would have amortized those costs over a shorter period of time than the schedule of amortization

that was used and/or an alternative way of looking at this is that the hospital could have incurred a higher interest cost on an annual basis from 1972 to 1985 and with that higher interest cost they have been [261] able to reduce or eliminate the issue costs that were paid out in 1972 and 1982, may have been able to reduce, eliminate, shorten, influence in some fashion the call premium provisions and arguably if the interest rate were set high enough could have been a high enough rate to enable for example the investment banker to sell the bonds at a sufficient premium that the investment banker could pay his sales commissions, pay other issues costs out of the premium provided from the bond holders. And there would in that situation not be cost to be amortized.

So I think the analogy works fairly well that in both cases we have assets which are established, a life is established for at the onset and it's everybody's best estimate of what that life is going to be subject to events show those estimates to have been inaccurate and in approaching the case of the depreciable asset and the GAAP approach, I believe common sense approach as it relates to a refinancing advanced refunding transaction is to recognize that as having happened over the past period and the way to deal with that is to recognize that in the period of that transaction.

Q. Now just continuing our CT scanner analogy, isn't what the Intermediary is saying is even though you [262] sold the CT scanner in your three and incurred a loss in your three, you have to continue to depreciate that asset over its remaining useful life regardless of the fact that you don't own it anymore?

A. That's my understanding of the Intermediary's argument.

Q. Does that make any sense from an accounting standpoint?

A. No, I don't believe so.

* * * * *

[282] The Witness: What this section does as Mr. Talbert indicated is implicitly recognize the gain or loss over some future period and it does that by in essence leaving the interest expense and the unamortized financing costs on the books and also placing the escrow funds on the books. And our point is that the hospital is not a party to any of those transactions, the debt [283] has been diffused and so to repeat, has been released from and is no longer part of the debt transaction.

* * * * *

[284] Q. How would Section 233 treat the losses associated with the call of the 1972 bonds in 1985?

A. It would have treated the call premium itself as a reimbursable cost in the 1985 cost report as I understand it and also would have included the loss reflected in 1985 based upon this PRM section, would have included any unamortized financing cost related to the 1972 issue.

Q. Is that treatment inconsistent with what they are in fact proposing to do on the out of adjustments for the hospital?

A. It's inconsistent and it points up the arbitrary nature of this section in that it continues to draw upon an activity that happens between the escrow and the bond holders in terms of the timing of that issue and it shows how decisions that were made in 1972 as to what interest rates and call premiums and issue costs and so forth, how the bond issue was structured, how several changes and those kind of decisions can influence in a decision in 1985 on what was the best economic approach to this, can influence the timing of the recognition of that loss.

* * * * *

[285] And I would simply point out that there are two items that might help eliminate that analysis, one is the fact that the hospital in this case incurred costs in excess of \$700,000 that it paid out of its pocket, they have to finance those but they were true costs just the same that were incurred by the hospital in 1972 and 1982. And those costs incurred in 1972 and 1982, in 1985 in essence is the time period in which the hospital would be recognizing the remaining previously recognized outlay of those expenditures.

* * * * *

[289] A. If I could answer what my understanding of GAAP and defer for a moment discussion of what the Intermediary's argument here is because I'm not sure I understand it. What these—represent are discussion that took place in 1972 regarding different practices that were in place at that particular point in time. And in its conclusion in 1972, the APB and statement number in opinion number 26 reached a conclusion that has been generally accepted accounting principles ever since and that is to recognize the gain or loss currently in income. I believe the Intermediary in this position is implying whether intended or not, there's an implication here that there are options and there are not for generally accepted accounting principles and—

Q. That's been the case since 1972?

A. That's correct.

* * * * *

[293] A. Yes. The hospital did incur "out of pocket" costs both in 1972 and in 1982 which is currently claiming the unamortized portion of those to be reimbursed to it. It also occurred costs in 1985 relating to the 1985 issue. It so happened that the hospital financed those issue costs from

borrowing but that should not change, that again seems to introduce a cash basis type of argument to determining the amount and the timing as to a loss that has been incurred and the hospital could have attributed those funds as opposed to financing them and therefore that's the Intermediary's more narrow definition of "out of pocket" type of expenses.

The cost again that has been incurred and no distinction should be drawn, there is no distinction drawn in the aggregate between the cost of patient care between GAAP and Medicare cost of patient care and generally accepted accounting principles and there should be no difference in treatment as it relates to the current period 1985. Again, the loss that's been incurred is one that's been incurred over the period 1972 through 1985.

* * * * *

[303] A. That's right, and the purpose of these and the purpose of the American Institute of CPAs Code of Professional Ethics rule number 203 there specifies that an auditor should not express an unqualified opinion if financial statements contain the material of departure from such pronouncements. And that rule defined such pronouncements as those statements by the Financial Accounting Standards Board.

Q. So the APB and FASB, they reflect the accounting profession's decision on matters of which might be reasonable disagreement among accountants but in order to get uniformity in the presentation of financial statements, once the controversy is identified you've got to say do it this way all the time or do it that way all the time and that's why something like APB 26 would be issued in the first place?

A. I believe that is a fair statement.

* * * * *

[321] Q. Now let's go to Section 223, why is that not appropriated, in other words why does not that result in payments of services rendered to Medicare beneficiaries in the year in which those services are rendered?

A. Because Section 233.3 is tying the recognition of the loss to future periods in treating the Provider as if the refunded debt was still on its books and treating it as if the hospital Provider was still a party to those two—to the refunded debt issues. And I'm going to argue arbitrarily tying that to the activity within an escrow account to which the hospital is not a party and forcing the Provider to continue to amortize unamortized discounts and premiums on the old debt while at the same time the provider has incurred additional debt issue costs on the refunding debt and is amortizing those over the future. It's forcing recognition into the future for something that had happened in which the Provider cannot reverse in the current period.

* * * * *

[322] Q. Section 233.3 states, B-3, "Call premiums are allowable in periods older than the refunded debts receive the principal payment." Is that true, does that make sense, I mean—I used the term, it made sense, I mean but does that reflect the reality of payments and the benefit of the hospital?

A. I don't believe it does because that's simply a function of the market conditions, for example in 1982, let's say that a call provision in 1987 for example was marketable could be sold to investors. In 1985 when this transaction happened, this issue would have been configured in such a way that it would be assumed the expert trustee would call them all in 1987 and it would result in a different answer then resolved in this situation. And yet it's again time to a bond issue for which the hospital is now claiming.

* * * * *

[334] A. I would paraphrase Charlotte Memorial to say that a Provider's decision to advance refund by placing X dollars into an escrow account triggers a present obligation on the part of the Provider to incur costs that are the current period loss on an advanced refunding. And that the fact that the bond holder receives the monies, its actual receipt of the money, receipt of the future does not detract from the fact that the hospital, the provider has already incurred a cost in the current period.

* * * * *

[337] A. And my point there only was that on this particular transaction I see no distinction between the cost of running a business and the cost of patient care. I think it's agreed that the debt is patient care related and therefore cost relating to a patient care related and if that is a critical part of the scrutiny, the focus of the scrutiny in determining whether a departure is allowed or permitted, I would argue that PRM 233.3 does not meet that test.

* * * * *

[338] Q. What weight does this carry in accounting, the descents?

A. I would say very little. I think a couple points there, one is there were three descending votes out of 18 so there was a pretty strong majority voting in favor of this pronouncements and secondly, once this [339] is approved in this fashion, that becomes part of Generally Accepted Accounting Principles in and of itself and on its own merits. The fact that there was a negative vote would not give a practicing accountant the ability to issue or properly issue a financial statement that departed from this statement. Even though there's a descent, he would still be bound by this in issuing a financial statement.

* * * * *

[ANDREWS TESTIMONY]

* * * * *

[359] Q. Well I agree with you that had they not refunded but given the fact that they didn't refund, I'm having a problem saying is this a cost incurred by the Provider, I don't think it is. And if you have a different — if you disagree with me, I'd like to know the basis of your saying it was a cost incurred by the Provider in subsequent years given that it was refinanced, how could it be incurred by them since they had no liability for it, how could it be incurred by [360] them. I'd like to understand your position?

A. As far as looking at the status, the Provider, they may not have the legal responsibility for the debt however, there's still the responsibility that the debt still exists and it's monies that were benefiting future periods instead of being patient care periods, you know I know they're not making an actual cash payment but they've paid it off with the proceeds of the 1985 bonds, so there's still an expense of the future period.

Q. I agree to the extent of the future period but to who is it an expense, of the Provider in the future period or is it an expense of the trustee?

A. The trustee is going to be making the payment but indirectly it would have been an expense of the Provider.

Q. Whose financial statements would the expense appear on?

A. The expense is not going to appear on the financial statement.

Q. It would appear on the financial statements of the trustee would it not?

A. Well yes.

Q. Is it a cost incurred by the trustee?

A. The trustee would be making the actual payments.

[361] Q. It was a cost incurred by the trustee in addition to making the payment, it was a cost incurred by the trust?

A. Yes.

* * * * *

BEFORE THE
PROVIDER REIMBURSEMENT REVIEW BOARD
BALTIMORE, MARYLAND

Case No. 88-1092
FYE: December 31, 1984
and
December 31, 1985

GUERNSEY MEMORIAL HOSPITAL
PROVIDER NO. 36-0203, PROVIDER

v.

BLUE CROSS AND BLUE SHIELD ASSOCIATION/COMMUNITY
MUTUAL INSURANCE COMPANY, FISCAL INTERMEDIARY

STIPULATION OF FACTS

The Provider, Guernsey Memorial Hospital, and the Fiscal Intermediary, Blue Cross and Blue Shield Association and Community Mutual Insurance Company, hereby agree and stipulate as follows:

1. On February 1, 1985, the Provider advance refunded 1972 and 1982 hospital improvement mortgage revenue bonds at a loss in the amount of \$672,581.00 (the "refinancing loss").

2. In its cost report for the fiscal year ending December 31, 1985, the Provider claimed the full loss on refinancing as a reimburseable cost.

3. In its Notice of Program Reimbursement for the fiscal year ending December 31, 1985 (the "NPR"), the Intermediary disallowed the full refinancing loss and re-

quired that the same be amortized over the life of the refunded bonds.

4. The Intermediary's treatment of the refinancing loss in the NPR is different from the recognition of such a loss as prescribed by generally accepted accounting principles (GAAP).

This Stipulation of Facts may be executed in multiple counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

GUERNSEY MEMORIAL HOSPITAL

By: /s/ Scott Taebel

SCOTT W. TAEBEL

Its: Attorney

Date: 8/16/1989

BLUE CROSS AND BLUE SHIELD
ASSOCIATION

By: /s/ Bernard M. Talbert

Title: Assoc. Gen. Counsel

Date: 8/17/89

COMMUNITY MUTUAL INSURANCE
COMPANY

By: _____

Title: _____

Date: _____

[EXHIBIT P-20]

STATEMENT OF
FINANCIAL ACCOUNTING
STANDARDS NO. 76

Extinguishment of Debt
an amendment of APB Opinion No. 26

November 1983

Financial Accounting Standards Board

Summary

This Statement provides guidance to debtors as to when debt should be considered to be extinguished for financial reporting purposes. This project was undertaken in response to requests to clarify the circumstances that constitute extinguishment and because the Board learned of growing diversity in practice.

This Statement specifies that debt is to be considered extinguished if the debtor is relieved of primary liability for the debt by the creditor and it is probable that the debtor will not be required to make future payments as guarantor of the debt. This Statement also specifies that, even though the creditor does not relieve the debtor of its primary obligation, debt is to be considered extinguished if (a) the debtor irrevocably places cash or other essentially risk-free monetary assets in a trust solely for satisfying that debt and (b) the possibility that the debtor will be required to make further payments is remote. This Statement amends APB Opinion No. 26, *Early Extinguishment of Debt*, to make it apply to all extinguishments of debt, whether early or not, other than those currently exempted from its scope, such as debt conversions and troubled debt restructurings.

This Statement is applicable to transactions occurring after December 31, 1983, with earlier application encouraged in annual financial statements that have not been previously issued. This Statement also permits the restatement of previously issued financial statements to apply this Statement retroactively.

**STATEMENT OF
FINANCIAL ACCOUNTING
STANDARDS NO. 76**

Extinguishment of Debt
an amendment of APB Opinion No. 26

November 1983

Financial Accounting Standards Board
of the Financial Accounting Foundation
High Ridge Park, P.O. Box 3821,
Stamford, Connecticut 06905-0821

**Statement of Financial Accounting Standards No. 76
Extinguishment of Debt
an amendment of APB Opinion No. 26
November 1983**

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Statement of Financial Accounting Standards No. 76

Extinguishment of Debt

an amendment of APB Opinion No. 26

November 1983

INTRODUCTION AND SCOPE

1. This Statement addresses what shall be considered to be an extinguishment of debt, which in turn affects when the debtor recognizes a gain or loss on extinguishment. This Statement does not address the accounting for redeemable preferred stock. The circumstances for an extinguishment of debt described in paragraphs 3(b) and 3(c) do not apply to debt that is convertible into the debtor's equity securities. Furthermore, the circumstances for an extinguishment of debt described in paragraph 3(c) apply only to debt with specified maturities and fixed payment schedules; consequently, those circumstances do not apply to debt with variable terms that do not permit advance determination of debt service requirements, such as debt with a floating interest rate.

2. Because extinguishment of debt currently is addressed by APB Opinion No. 26, *Early Extinguishment of Debt*, that Opinion is amended to refer to the standards in this Statement for guidance about what shall be considered to be an extinguishment of debt. This Statement also amends that Opinion to make it apply to all extinguishments of debt, whether early or not, other than those currently exempted from its scope, such as debt conversions as described in that Opinion and troubled debt restructurings as described in FASB Statement No. 15, *Accounting by Debtors and Creditors for Troubled Debt Restructurings*.

STANDARDS OF FINANCIAL ACCOUNTING AND REPORTING

Circumstances for an Extinguishment of Debt

3. A debtor shall consider debt to be extinguished for financial reporting purposes in the following circumstances:

- a. The debtor pays the creditor and is relieved of all its obligations with respect to the debt. This includes the debtor's reacquisition of its outstanding debt securities in the public securities markets, regardless of whether the securities are cancelled or held as so-called treasury bonds.
- b. The debtor is legally released¹ from being the primary obligor under the debt either judicially or by the creditor and it is probable² that the debtor will not be required to make future payments with respect to that debt under any guarantees.
- c. The debtor irrevocably places cash or other assets in a trust to be used solely for satisfying scheduled payments of both interest and principal of a specific obligation and the possibility that the debtor will be required to make future payments with respect to that debt is remote. In this circumstance, debt is extinguished even though the debtor is not legally released from being the primary obligor under the debt obligation.

¹ If nonrecourse debt (such as certain mortgages) is assumed by a third party in conjunction with the sale of an asset that serves as the sole collateral for that debt, the sale and related assumption effectively accomplish a legal release of the seller/debtor for purposes of applying this Statement.

² Probable is used here, consistent with its use in FASB Statement No. 5, *Accounting for Contingencies*, to mean that it is likely that no payments will be required.

Restrictions on the Nature of Assets in Trust

4. The following requirements regarding the nature of the assets held by the trust shall be met to effect an extinguishment of debt under paragraph 3(c):

- a. The trust shall be restricted to owning only monetary assets³ that are *essentially risk free* as to the amount, timing, and collection of interest and principal. The monetary assets shall be denominated in the currency in which the debt is payable. For debt denominated in U.S. dollars, essentially risk-free monetary assets shall be limited to:
 - (1) Direct obligations of the U.S. government
 - (2) Obligations guaranteed by the U.S. government
 - (3) Securities that are backed by U.S. government obligations as collateral under an arrangement by which the interest and principal payments on the collateral generally flow immediately through to the holder of the security.

However, some securities described in the previous sentence can be paid prior to scheduled maturity and so are not essentially risk free as to the *timing* of the collection of interest and principal; thus, they do not qualify for ownership by the trust.

- b. The monetary assets held by the trust shall provide cash flows (from interest and maturity of those assets) that approximately coincide, as to timing and amount, with the scheduled interest and principal payments on the debt that is being extinguished.

³ A monetary asset is money or a claim to receive a sum of money that is fixed or determinable without reference to future prices of specific goods or services.

Costs Related to Placing Assets in Trust

5. If, in conjunction with placing assets in trust to effect an extinguishment of debt, it is expected that trust assets will be used to pay related costs, such as trustee fees, as well as to satisfy scheduled interest and principal payments of a specific debt, those costs shall be considered in determining the amount of funds required by the trust. On the other hand, if the debtor incurs an obligation to pay any related costs, the debtor shall accrue a liability for those probable future payments in the period that the debt is recognized as extinguished.

Disclosures

6. If debt is considered to be extinguished under the provisions of paragraph 3(c), a general description of the transaction and the amount of debt that is considered extinguished at the end of the period shall be disclosed so long as that debt remains outstanding.

Amendments to Other Pronouncements

7. Paragraph 2 of Opinion 26, which addresses the applicability of that Opinion, is superseded and replaced by the following:

Applicability. This Opinion applies to all extinguishments of debt, whether early or not, except debt that is extinguished through a troubled debt restructuring and debt that is converted to equity securities of the debtor pursuant to conversion privileges provided in terms of the debt at issuance. It supersedes Chapter 15 of ARB No. 43 and paragraph 19 of APB Opinion No. 6. However, it does not alter the accounting for convertible debt securities described in APB Opinion No. 14.

8. Paragraph 3(a) of Opinion 26, which defines *early extinguishment*, is superseded and replaced by the following:

- a. *Extinguishment of debt*. FASB Statement No. 76, *Extinguishment of Debt*, defines transactions that the debtor shall recognize as an extinguishment of debt.

9. The following terms and phrases are deleted from Opinion 26 as indicated:

- a. In paragraph 3(c), the term *early*
- b. In paragraph 19, the phrase *before scheduled maturities*
- c. In paragraph 21, the phrase *before maturity*.

10. The last sentence of footnote 1 of FASB Statement No. 22, *Changes in the Provisions of Lease Agreements Resulting from Refundings of Tax-Exempt Debt*, which refers to AICPA Statement of Position (SOP) 78-5, *Accounting for Advance Refundings of Tax-Exempt Debt*, is superseded and replaced by the following:

FASB Statement No. 76, *Extinguishment of Debt*, provides criteria for determining whether the advance refunding should be recognized as an extinguishment of the existing debt at the date of the advance refunding.

11. The reference to SOP 78-5, *Accounting for Advance Refundings of Tax-Exempt Debt*, is deleted from Appendix A of FASB Statement No. 32, *Specialized Accounting and Reporting Principles and Practices in AICPA Statements of Position and Guides on Accounting and Auditing Matters*.

Effective Date and Transition

12. This Statement shall be effective for transactions entered into after December 31, 1983. Earlier application of this Statement is encouraged for transactions in fiscal years for which annual financial statements have not previously been issued. Furthermore, retroactive application of this Statement to transactions occurring during fiscal years for which annual financial statements have previously been issued is permitted, in which case the effects on restated per share amounts of prior years shall be disclosed.

The provisions of this Statement need not
be applied to immaterial items.

This Statement was adopted by the affirmative votes of four members of the Financial Accounting Standards Board. Messrs. Kirk, March, and Mosso dissented.

Messrs. Kirk, March, and Mosso dissent from this Statement because they do not believe that extinguishment of debt accounting and resultant gain or loss recognition should be extended to situations wherein the "debtor is not legally released from being the primary obligor under the debt obligation." (Refer to paragraph 3(c).) They believe such accounting should be limited to situations described in paragraphs 3(a) and 3(b), which are more consistent with both present practice and the concept in paragraph 143 of FASB Concepts Statement No. 3, *Elements of Financial Statements of Business Enterprises*, that "a liability once incurred by an enterprise remains a liability until it is satisfied in another transaction or other event or circumstance affecting the enterprise." In their opinion, the setting aside of assets in trust does not, in and of itself, constitute either the disposition of assets with potential

gain or loss recognition or the satisfaction of a liability with potential gain or loss recognition. Though dedicated to a single purpose, assets in the trust continue to be assets (that is, probable future economic benefits) of the debtor until applied to payment of the debt. Likewise, the liability continues to be a liability of the original debtor until satisfied by payment or by agreement of the creditor that the debtor is no longer the primary obligor. Dedication of the assets might ensure that the debt is serviced in timely fashion, but that event alone just matches up cash flows; it does not satisfy, eliminate, or extinguish the obligation. For a debt to be satisfied, the creditor must be satisfied.

Members of the Financial Accounting Standards Board:

Donald J. Kirk, *Chairman*
 Frank E. Block
 Victor H. Brown
 John W. March
 David Mosso
 Robert T. Sprouse
 Ralph E. Walters

[EXHIBIT P-22]

ESCROW AGREEMENT
 among
 CITY OF CAMBRIDGE, OHIO,
 GUERNSEY MEMORIAL HOSPITAL
 and
 BANCOHIO NATIONAL BANK

THIS ESCROW AGREEMENT dated as of February 1, 1985 (the "Agreement"), is made by and among the City of Cambridge, Ohio (the "Issuer"), a municipal corporation and political subdivision in and of the State of Ohio and duly organized and validly existing under the laws of the State, Guernsey Memorial Hospital (the "Hospital"), a nonprofit hospital agency as defined in Section 140.01, Ohio Revised Code, and BancOhio National Bank ("BancOhio"), a national banking association duly organized and validly existing under the laws of the United States and duly authorized to exercise corporate trust power under the laws of the State of Ohio;

W I T N E S S E T H :

WHEREAS, the Issuer has authorized, sold and delivered its \$7,600,000 Hospital Improvement First Mortgage Revenue Bonds, dated as of January 1, 1972, and its \$10,410,000 Hospital Improvement Mortgage Revenue Bonds, Series 1982 (Guernsey Memorial Hospital Project), dated as of October 1, 1982 (collectively, the "Refunded Bonds"), for the purpose of acquiring certain interests in real and personal property and constructing, improving, furnishing and equipping real and personal property comprising Hospital Facilities (the "Original Project"), as defined in Section 140.01(E), Ohio Revised Code, to be leased to and operated by the Hospital; and

WHEREAS, the Refunded Bonds were issued under and are secured by the Indenture of Mortgage, dated as of January 1, 1972, as supplemented and amended by the Supplemental Indenture of Mortgage, dated as of October 1, 1982 (collectively, the "Original Indenture"), both between the Issuer and BancOhio, as trustee (in its capacity as such, the "Escrow Trustee"); and

WHEREAS, the Issuer, at the request of the Hospital, has authorized, sold and delivered its \$15,375,000 Hospital Improvement Revenue Refunding Bonds, Series 1985 (Guernsey Memorial Hospital Project), dated as of February 1, 1985 (the "Refunding Bonds"), for the purpose of advance refunding the Refunded Bonds; and

WHEREAS, the Refunding Bonds are issued under and secured by a Trust Indenture (the "Refunding Indenture") between the Issuer and BancOhio, as trustee (in its capacity as such, the "Refunding Trustee"), dated as of February 1, 1985; and

WHEREAS, the Hospital, as lessee, and the Issuer, as lessor, have entered into a Lease, dated as of February 1, 1985 (the "Lease"), pursuant to which the Issuer has leased certain hospital facilities and the site thereof to the Hospital for operation by the Hospital and pursuant to which the Hospital is obligated to make rental payments to the Issuer sufficient to pay the principal of and interest and any premium on the Refunding Bonds when and as the same become due and payable; and

WHEREAS, it is the intent of this Agreement to provide for the application of the proceeds of the sale of the Refunding Bonds, in such manner as to cause the Original Indenture to be released and discharged pursuant to the terms of Article VIII thereof;

NOW, THEREFORE, IN CONSIDERATION of the mutual covenants contained herein, and in order to provide for the payment and discharge of the Refunded

Bonds and coupons appertaining thereto and to release and discharge the Original Indenture, and to better provide for the health and welfare of the residents of the Issuer by enhancing the economy of Hospital Facilities and the services provided thereby, the parties hereto covenant, agree and bind themselves as follows:

Section 1. In accordance with the provisions of Article VIII of the Original Indenture, there is hereby established with the Escrow Trustee and ordered maintained in a separate deposit account (except when invested as hereinafter provided) a trust fund to be designated "Guernsey Memorial Hospital Refunded Bond Escrow Fund" (the "Escrow Fund"). The Escrow Fund shall be in the custody of the Escrow Trustee and, together with the earnings thereon and investments therein, shall be held in trust for the holders of the Refunded Bonds and shall be used and applied for the payment of the principal of and interest on the Refunded Bonds as provided herein. The Escrow Trustee shall establish within the Escrow Fund two accounts, one account to be designated "Account A" ("Account A") and the second to be designated "Account B" ("Account B").

Section 2. The Refunding Trustee shall deposit into the Administrative Expense Fund for the Refunding Bonds, as defined in and established under the Refunding Indenture, the portion of the proceeds of the Refunding Bonds to be deposited therein as set forth in the Refunding Indenture. The balance of the proceeds of the Refunding Bonds, together with other available funds of the Issuer as provided by the Refunding Indenture and as described in the following paragraph, shall forthwith be delivered to the Escrow Trustee for deposit in the Escrow Fund and shall be immediately utilized by the Escrow Trustee to purchase the aggregate principal amount of direct obligations of the United States of America identified in Exhibit A

hereto. All proceeds of the Refunding Bonds deposited into the Escrow Fund shall be credited to Account A.

The Escrow Trustee shall deposit into Account B of the Escrow Fund all moneys in the Replacement and Improvement Fund for the Refunded Bonds (less any amounts required for the Debt Service Reserve Fund as defined in the Refunding Indenture), the Contingency Reserve Fund for the Refunded Bonds and certain moneys in the Debt Service Reserve Fund for the Refunded Bonds (to the extent not deposited in the Debt Service Reserve Fund as defined in the Refunding Indenture), all as defined in and established under the Original Indenture. The Escrow Trustee shall, to the extent such moneys are not already so invested, immediately utilize such moneys described in the proceeding instance to purchase direct obligations of the United States of America as described in the preceding paragraph.

Section 3. The Issuer has heretofore found and determined that such investments required pursuant to Section 2 of this Agreement are advantageous in yield and maturity date in order to make available the necessary moneys to provide for the payment of principal of, redemption premium on and interest on the Refunded Bonds pursuant to Article VIII of the Original Indenture, to release and discharge the Original Indenture and to meet the applicable requirements of the regulations of the United States Treasury Department adopted pursuant to Section 103(c) of the Internal Revenue Code of 1954, as amended. If at any time any moneys in the Escrow Fund which have been derived from investment of moneys in the Escrow Fund shall not be required for the payment of principal of, redemption premium on or interest on the Refunded Bonds, the Escrow Trustee shall reinvest such moneys in United States Treasury Obligations, State and Local Government Series bearing interest at a rate of 0% in minimum

amounts of \$1000 and in multiples of \$100 above such amount for maturity six months later.

Section 4. The Escrow Fund, including all investments thereof and the income derived from said investment, shall be held by the Escrow Trustee and shall be used to (i) pay the interest on the Refunded Bonds, dated as of January 1, 1972, which interest is due and payable on each June 1 and December 1, commencing June 1, 1985, through and including December 1, 1996, the date of their final maturity, (ii) to pay the interest on the Refunded Bonds, dated as of October 1, 1982, which interest is due and payable on each June 1 and December 1, commencing June 1, 1985, through and including December 1, 1992, the date of optional redemption, (iii) to retire on their stated maturity date the Refunded Bonds, dated as of January 1, 1972, and (iv) to retire on December 1, 1992, pursuant to call for redemption, the Refunded Bonds dated as of October 1, 1982, including any premium payable in connection with such retirement by redemption, and the interest falling due on such date. Moneys in the Escrow Fund shall, and the Escrow Trustee agrees such moneys will, be used for the purpose as described above and the deposit of such moneys in the Escrow Fund shall be irrevocable. The Escrow Trustee further agrees that it will not surrender or otherwise attempt to redeem or otherwise negotiate the investments in the Escrow Fund except as they shall come due as shown on said attached Exhibit A. Subject to the foregoing requirements for the use of the Escrow Fund and the moneys and investments therein and except as otherwise provided herein, the Issuer and the Hospital covenant and agree that the Escrow Trustee shall have full and complete control and authority over and with respect to the Escrow Fund and moneys and investments therein, and that the Issuer and the Hospital shall not exercise any

control or authority over and with respect to the Escrow Fund and the moneys and investments therein.

Section 5. The Escrow Trustee acknowledges that it has received (i) a certificate of an independent public accounting firm of national reputation certifying that the moneys and investments in the Escrow Fund satisfy the requirements of Article VIII of the Original Indenture and (ii) an opinion of Squire, Sanders & Dempsey, Bond Counsel, stating that the conditions precedent to the release and discharge of the Original Indenture have been complied with. The Escrow Trustee shall execute and deliver to the Issuer and the Hospital such instruments as are requested of it to evidence the discharge and release of the lien of the Original Indenture.

Section 6. The Issuer hereby acknowledges receipt of notice of the termination of the Lease between the Issuer and the Hospital, dated as of January 1, 1972, as supplemented and amended by the Supplemental Lease, dated as of October 1, 1982 (collectively, the "Original Lease"), and relating to the Refunded Bonds, as required to be given by the Hospital pursuant to Section 10.1 of said Original Lease. The Issuer also acknowledges receipt of notice of the Hospital's exercise of its option to purchase the Original Project pursuant to Section 10.3 of the Original Lease.

Section 7. The Escrow Trustee hereby represents that it has caused notice of the redemption of the Refunded Bonds, dated as of October 1, 1982, to be published in accordance with the requirements of the Original Indenture.

Section 8. The Escrow Trustee is hereby authorized and directed to immediately publish notice of the defeasance of the Original Indenture and the deposit of the direct obligations of the United States of America in the Escrow Fund.

Section 9. The trust and fiduciary relationship created by this Agreement is irrevocable and intended for the benefit of the holders from time to time of the Refunded Bonds. The moneys realized from the interest on and principal of the investments in the Escrow Fund are hereby dedicated to and pledged for the payment of the principal of and interest on the Refunded Bonds. Such moneys are subject to the lien of such pledge, which shall be valid and binding against all parties having claims of any kind against the Issuer, the Hospital or BancOhio as the Escrow Trustee and the Refunding Trustee, and which pledge shall constitute a perfected security interest, and such moneys and investments shall be used for the purposes stated herein. The lien and security interest granted pursuant to this Agreement shall take effect on the date of delivery of this Agreement and shall remain in full force and effect on the date of delivery of this Agreement and shall remain in full force and effect until the terms of this Agreement have been satisfied and the moneys and the investments in the Escrow Fund have been applied as contemplated herein.

Section 10. In the event that the Escrow Trustee determines that there are moneys in the Escrow Fund in excess of the amounts required to provide for payment of the interest on and principal of the Refunded Bonds, the Escrow Trustee shall promptly notify the Hospital in writing of such excess and, upon request by the Hospital, shall deliver such excess moneys to the Hospital. After payment in full of all interest on and the principal of the Refunded Bonds in accordance with the Original Indenture and of any fees or expenses of the Escrow Trustee not previously paid or provided for, the Escrow Trustee shall deliver all remaining moneys in the Escrow Fund to the Hospital. All moneys delivered by the Escrow Trustee to the Hospital pursuant to this Section 10 shall no longer be

subject to the lien and security interest granted in Section 9 of this Agreement.

Section 11. The Hospital hereby agrees to pay to the Escrow Trustee all fees and charges of the Escrow Trustee for its services under this Agreement and the Original Indenture, in the same manner and to the same extent that such fees and charges would have been payable under the Original Indenture. The Escrow Trustee hereby acknowledges that the above agreement by the Hospital to pay the Escrow Trustee's fees and charges is satisfactory to it in accordance with the provisions of the Original Indenture for the release and discharge thereof.

Section 12. If any provision of this Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision hereof.

Section 13. This Agreement shall inure to the benefit of and shall be binding upon the Issuer, the Hospital, BancOhio as the Escrow Trustee and the Refunding Trustee, and the holders of the Refunded Bonds, and their respective successors and assigns, all subject to the provisions of this Agreement.

This Agreement may be executed in several counterparts, each of which shall be an original and all of which shall constitute but one and the same instrument.

IN WITNESS WHEREOF, the Issuer, the Hospital, the Escrow Trustee and the Refunding Trustee, have caused this Agreement to be executed in their respective names and capacities by their duly authorized officers, all as of the day and the year first written above.

CITY OF CAMBRIDGE, OHIO, Issuer

By: /s/ C. Charles Schaub

Mayor

And By: /s/ Donna Gander

Auditor

GUERNSEY MEMORIAL HOSPITAL

By: /s/ [Signature Illegible]

President

And By: /s/ Mrs. James (Mary K.) Cole

Secretary

BANC OHIO NATIONAL BANK, as Escrow
Trustee and Refunding Trustee

By: /s/ C. Joseph Serle

Title: Vice President

And By: /s/ Timothy Kalys

Title: Assistant Vice President

The form and correctness of the within instrument are hereby approved:

By: /s/ Gerald L. Jones

Director of Law

EXHIBIT A

Direct obligations of the United States of America held
in the Escrow Fund:

Account A

United States Treasury Certificates of Indebtedness —
State and Local Government Series

<u>Amount</u>	<u>Interest Rate</u>	<u>Maturity Date</u>
\$36,900	6.894%	6/1/85

United States Treasury Notes —
State and Local Government Series

<u>Amount</u>	<u>Interest Rate</u>	<u>Maturity Date</u>
\$271,600	9.497%	12/1/86
308,300	10.063	12/1/87
128,000	10.681	12/1/90
2,700	10.751	06/1/91
467,700	10.821	12/1/91
11,800	10.861	06/1/92
11,224,700	10.900	12/1/92
457,800	10.941	12/1/93
510,700	10.970	12/1/94

United States Treasury Bonds —
State and Local Government Series

<u>Amount</u>	<u>Interest Rate</u>	<u>Maturity Date</u>
\$566,900	10.991%	12/1/95
626,600	11.010	12/1/96

Account B

<u>Amount</u>	<u>Interest Rate</u>	<u>Maturity Date</u>	<u>Description of Obligation</u>
\$600,000	10.75%	11/15/89	United States Treasury Notes
472,000	9.875	05/15/88	United States Treasury Notes
325,000	(1)	05/23/85	United States Treasury Bills

(1) Bought at purchase price of \$316,075.76.

[EXHIBIT P-23]

Filed with Guernsey County Recorder on 2/27/85 at 8:52 a.m., Lease Vol. 100, p. 1 (cross-referenced in Mortgage Vol. 11, p. 167)

**TERMINATION OF LEASE AND SUPPLEMENTAL LEASE,
RELEASE AND DISCHARGE OF INDENTURE OF MORTGAGE
AND SUPPLEMENTAL INDENTURE OF MORTGAGE
AND RELEASE OF GUARANTY**

KNOW ALL MEN BY THESE PRESENTS THAT:

WHEREAS, in connection with the issuance by the City of Cambridge, Ohio (the "Issuer") of its \$7,600,000 Hospital Improvement First Mortgage Revenue Bonds (the "1972 Bonds"), the Issuer and Guernsey Memorial Hospital (the "Lessee") entered into the Lease (the "Original Lease"), dated as of January 1, 1972, which Original Lease was recorded in the Lease Records (the "Lease Records") of the Recorder of Guernsey County, Ohio as Instrument No. 23073 at Volume 69, Page 1;

WHEREAS, in connection with the issuance by the Issuer of its \$10,410,000 Hospital Improvement Mortgage Revenue Bonds, Series 1982 (Guernsey Memorial Hospital Project) (the "1982 Bonds"), the Issuer and the Lessee entered into the Supplemental Lease (the "Supplemental Lease"), dated as of October 1, 1982, which Supplemental Lease was recorded in the Lease Records as Instrument No. 86196 at Volume 94, Page 705;

WHEREAS, to secure the 1972 Bonds, the Issuer and BancOhio National Bank (formerly known as The Ohio National Bank of Columbus) (the "Trustee") entered into the Indenture of Mortgage (the "Original Indenture"), dated as of January 1, 1972, which Original Indenture was recorded in the Mortgage Records (the "Mortgage Records") of the Recorder of Guernsey County, Ohio as Instrument No. 23074 at Volume 237, Page 270;

WHEREAS, to secure the 1982 Bonds, the Issuer and the Trustee entered into the Supplemental Indenture of Mortgage (the "Supplemental Indenture"), dated as of October 1, 1982, which Supplemental Indenture was recorded in the Mortgage Records as Instrument No. 86197 at Volume 297, Page 524;

WHEREAS, to further secure the 1982 Bonds, the Hospital and the Trustee entered into the Guaranty Agreement (the "Guaranty"), dated as of October 1, 1982, whereby the Hospital guaranteed the full and prompt payment of the principal of and premium, if any, and interest on the 1982 Bonds when due;

WHEREAS, provision has been made under the applicable provisions of the Original Indenture for the Trustee to hold, in trust and irrevocably committed to the payment and discharge of all of the 1972 Bonds and the 1982 Bonds, direct obligations of the United States of America certified by an independent accounting firm of national reputation to be of such maturities and interest payment dates and to bear such interest as will, without further investment or reinvestment of either the principal amount thereof or the interest earnings thereon, be sufficient, together with any money held by the Trustee for such purpose, for the payment in accordance with the terms of the 1972 Bonds and the 1982 Bonds, of the principal of and interest and premium, if any, on the 1972 Bonds and the 1982 Bonds such that the 1972 Bonds and the 1982 Bonds, in accordance with Section 8.02 of the Original Indenture, shall be deemed to have paid and discharged; and

WHEREAS, the conditions under which (i) the Original Lease may be terminated, (ii) the Guaranty may be released and (iii) the Original Indenture and the Supplemental Indenture may be released, cancelled and discharged under the applicable provisions of each document, have been, or will be under provisions satisfactory

to the Trustee, met and, accordingly, the Issuer is authorized to obtain the termination of the Original Lease and the Supplemental Lease and the release of the Guaranty, the Original Indenture and the Supplemental Indenture, including the cancellation and discharge of the lien of each.

NOW, THEREFORE, the Issuer, the Lessee and the Trustee hereby agree, confirm and declare that the Original Lease and the Supplemental Lease have been and are terminated, that the Guaranty has been released and that the Original Indenture and the Supplemental Indenture have been and are satisfied and, by this instrument, release, cancel and discharge the Original Indenture and the Supplemental Indenture. The Issuer, the Lessee and the Trustee further request that written notification to that effect be made by the Recorder of Guernsey County, Ohio on the recorded Original Lease, Supplemental Lease, Original Indenture and Supplemental Indenture.

IN WITNESS WHEREOF, the Issuer, the Lessee and the Trustee, respectively, have caused this instrument to be executed and delivered by their duly authorized officers as of February 27, 1985.

Signed and acknowledged as to the Issuer
in the presence of:

	CITY OF CAMBRIDGE, OHIO
/s/ <u>Sharon K. Stan</u>	By: /s/ <u>C. Charles Schaub</u>
	Mayor
/s/ <u>Carol J. Lorey</u>	Attest: /s/ <u>Donna Gander</u>
(Witnesses as to the Issuer)	Auditor

Signed and acknowledged as to the Lessee
in the presence of:

	GUERNSEY MEMORIAL HOSPITAL
/s/ <u>Carol J. Lorey</u>	By: /s/ <u>[Signature Illegible]</u>
	President (Title)
/s/ <u>Pamela S. Steele</u>	Attest: /s/ <u>Mrs. James (Mary K.) Cole</u>
(Witnesses as to the Lessee)	Secretary (Title)

Signed and acknowledged as to the Trustee
in the presence of:

	BANC OHIO NATIONAL BANK
/s/ <u>Sylvia L. Kendrick</u>	By: /s/ <u>C. Joseph Serle</u>
	(Title)
/s/ <u>Kathleen E. Harter</u>	Attest: /s/ <u>Timothy Kelly</u>
(Witnesses as to the Trustee)	(Title)

The legal form and substance of the within instrument are hereby approved:

By: /s/ Gerald L. Jones
Director of Law
City of Cambridge, Ohio

\$7,600,000 CITY OF CAMBRIDGE, OHIO Hospital Improvement First Mortgage Revenue Bonds

No. 770

(Guernsey Memorial Hospital — Lessee)

Dated: January 1, 1972

Due: December 1, 1975-1996

Principal (December 1) and semi-annual interest (June 1 and December 1) payable at the corporate trust office of The Ohio National Bank of Columbus, Columbus, Ohio, Trustee. The Bonds are issuable as coupon Bonds registrable as to principal only or as to both principal and interest in multiples of \$5,000 and interchangeable as provided in the Indenture. First coupon payable June 1, 1972.

MATURITY SCHEDULE

(December 1)				
Year	Amount	Coupon Rate	Price or Yield	Year
1975	\$150,000	5¼ %	4.25 %	1980
1976	160,000	5¼	4.50	1981
1977	170,000	5¼	4.75	1982
1978	185,000	5¼	5.00	1983
1979	200,000	5¼	100	1984
			Amount	Coupon Rate
			\$215,000	6 %
			230,000	6
			245,000	6
			260,000	6
			285,000	6
				Price or Yield
				5.50 %
				5.65
				5.80
				5.90
				100

TERM BONDS

\$5,500,000 7% Due December 1, 1996 Price 100%

(accrued interest to be added)

Any of the Project Bonds maturing on December 1, 1996, which are outstanding, are subject to redemption pursuant to the mandatory sinking fund requirements of the Bond Resolution, on December 1, 1985, and each December 1 thereafter to and including December 1, 1996, at 100% of the principal amount thereof plus accrued interest to the redemption date. (See Schedule of Principal and Interest Requirements, Page 6.)

Unless redeemed pursuant to the preceding paragraph, any of the Project Bonds as may be outstanding and mature on December 1, 1996, are subject to optional redemption by the City prior to maturity on any interest payment date on or after December 1, 1984, in whole or in part, at the redemption price (expressed as percentages of the principal amount) as set forth below, plus accrued interest to the redemption date:

Redemption Period (dates inclusive)	Redemption Price
December 1, 1984 to December 1, 1986	104%
June 1, 1986 to December 1, 1988	103%
June 1, 1989 to December 1, 1990	102%
June 1, 1991 to December 1, 1993	101%
June 1, 1994 and thereafter	100%

Interest Exempt, in the opinion of Bond Counsel from Federal Income Taxes, under existing Statutes, Court Decision, Regulations and Rulings, and exempt from the Ohio personal income tax. (See page 26 herein). For status under "Phase II Price Controls", see page 3 herein.

The Project Bonds are being issued under authority of Section 3 of Article XVIII of the Ohio Constitution, Chapter 140, Ohio Revised Code, and Ordinance No. 4-72 of the City of Cambridge passed on January 18, 1972, as amended, and constitute special obligations of the City payable solely from a pledge of net revenues and other moneys received by the City from the operation of the hospital and from the rentals under its lease to Guernsey Memorial Hospital, a non-sectarian corporation not for profit, which rentals are secured by a gross pledge of earnings by said corporation. Neither the faith and credit nor the taxing power of the City or any other political subdivision is pledged to the payment of the principal of or the interest on the Bonds.

The Bonds are legal investments in the State of Ohio for banks, savings banks, building and loan associations, insurance companies, fiduciaries, certain trust funds and are also acceptable as security for the deposit of public moneys. (See page 3 herein.)

These bonds are offered subject to prior sale, when, as and if issued and received by us, subject to approval of legality by Messrs. Squire, Sanders & Dempsey, Cleveland, Ohio. The Financial Feasibility of the project has been studied by the firm of Ernst & Ernst and their report is included herein.

THE OHIO COMPANY

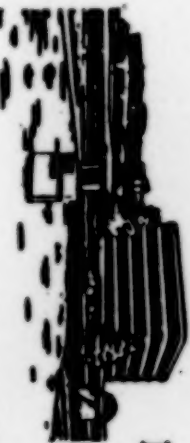
McDONALD & COMPANY

The Date of this Official Statement is January 25, 1972

NEW ISSUE

Rating: Standard & Poor's BBB(p)

In the opinion of Bond Counsel interest on the Bonds is exempt under existing law from federal income tax, the Ohio corporate franchise tax, Ohio personal income tax and municipal income taxes in Ohio; and the Bonds are exempt from Ohio intangible property taxes. (See "Tax Exemption" at page 32 herein.)



**OFFICIAL STATEMENT
RELATING TO THE ORIGINAL ISSUANCE OF
\$10,410,000
City of Cambridge, Ohio
HOSPITAL IMPROVEMENT MORTGAGE REVENUE BONDS,
SERIES 1982
(GUERNSEY MEMORIAL HOSPITAL PROJECT)**

Dated: October 1, 1982

Due: December 1, 2002 and
December 1, 2012

The Bonds are issuable as negotiable coupon bonds in the denominations of \$5,000, registrable as to principal only and as fully registered bonds, without coupons, registered as to both principal and interest, in denominations of \$5,000 and whole multiples thereof, and interchangeable as provided in the Indenture. Interest is payable semiannually on June 1 and December 1, commencing December 1, 1982, and principal is payable as set forth below at the corporate trust office of the Trustee, currently BancOhio National Bank, Columbus, Ohio.

Principal of, premium, if any, and interest on the Bonds are payable primarily from rentals paid to the City of Cambridge, Ohio, by Guernsey Memorial Hospital, as lessee and Guarantor. Neither the general resources, the full faith and credit, nor the taxing power of the City, the State, or any political subdivision are pledged to the payment of the principal of and premium, if any, and interest on the Bonds, which are special obligations of the City.

MATURITY SCHEDULE

Term Bonds			
Year	December 1	Coupon Rate	Price or Yield(1)
2002	\$3,000,000	12.0%	100%
2012	7,410,000	12.5	100

(1) Plus accrued interest from October 1, 1982.

Redemption Prior to Maturity: The Bonds are callable for redemption, prior to maturity (1) in whole or in part, on any interest payment date on and after December 1, 1992, to retire Bonds optionally, (2) in part on December 1 of each of the years 1997 through 2001 and 2003 through 2011, pursuant to sinking fund requirements, to retire mandatorily the Term Bonds maturing December 1, 2002 and December 1, 2012, respectively, (3) in whole or in part, at any time, as a result of certain defined events such as damage to, destruction or condemnation of or other events relating to the Project all as set forth hereinafter and more specifically in the Indenture. (See "The Bonds—Bond Redemption Prior to Maturity" at page 7 herein.)

The Bonds are offered, subject to prior sale, to withdrawal or to modification of the offer without any notice, when, as and if issued by the City and received by the Underwriters, subject to approval of certain legal matters relating to the issuance of the Bonds, by Squire, Sanders & Dempsey, Bond Counsel. Certain legal matters will be passed upon for the Hospital by Tribbie, Scott and Moorehead, and for the Underwriters by Gingham & Christensen. A study of the financial feasibility of the Addition, conducted by Ernst & Whinney, is included herein as Appendix II. The initial yield or offering price set forth above and concessions in transactions with securities dealers may be changed by the Underwriters. The Bonds are expected to be available for delivery in definitive form in Columbus, Ohio, on or about October 26, 1982.

THE OHIO COMPANY

MCDONALD & COMPANY

Dated October 12, 1982

* * * * *

Bond Redemption Prior to Maturity

Optional. The Bonds are redeemable at the option of the City, at the request of the Hospital, in inverse order of maturity (and by lot within maturity), either in whole or in part, on any interest payment date not earlier than December 1, 1992, at the redemption price (expressed as a percentage of principal amount) set forth below, plus accrued interest to the redemption date:

<u>Redemption Dates</u>	<u>Redemption Price</u>
December 1, 1992 and June 1, 1993	103.0%
December 1, 1993 and June 1, 1994	102.5%
December 1, 1994 and June 1, 1995	102.0%
December 1, 1995 and June 1, 1996	101.5%
December 1, 1996 and June 1, 1997	101.0%
December 1, 1997 and June 1, 1998	100.5%
December 1, 1998 and thereafter	100.0%

Mandatory. The Bonds maturing December 1, 2002 and December 1, 2012 are subject to mandatory redemption according to the schedule set forth below, from monies required to be deposited in the Debt Service Fund, at the principal amount thereof and accrued interest and without premium.

The principal amount of Bonds required to be redeemed on each mandatory redemption date shall be reduced by the principal amount of any such Bonds which at least 45 days prior to said mandatory redemption date shall have been purchased by the Trustee from monies available therefor or have been delivered to the Trustee for cancellation.

The mandatory redemption schedule is as follows:

<u>Year</u>	<u>Bonds Due December 1, 2002</u>	<u>Year</u>	<u>Bonds Due December 1, 2012</u>
1997	\$ 370,000	2003	\$ 410,000
1998	415,000	2004	465,000
1999	465,000	2005	520,000
2000	520,000	2006	585,000
2001	580,000	2007	660,000
		2008	745,000
		2009	835,000
		2010	940,000
		2011	1,060,000

Extraordinary Redemption. The Bonds may be called for redemption prior to maturity at the principal amount thereof and accrued interest, without premium, as a whole on any date if the Leased Premises are substantially damaged or destroyed, or the Lease becomes void or unenforceable, or certain other events occur and in whole or in part if title to all or substantially all of the Project is taken under power of eminent domain. (See "The Lease—Hospital's Options to Terminate Lease" at page 26 herein.)

* * * * *

[EXHIBIT P-28]

STATEMENTS OF REVENUES AND EXPENSES
GUERNSEY MEMORIAL HOSPITAL

	Year Ended December 31	
	1985	1984
Patient service revenues		
Daily patient services	\$ 9,969,440	\$10,074,172
Other nursing services	5,191,425	4,471,133
Other professional services	11,637,174	8,987,974
	<u>26,798,039</u>	<u>23,533,279</u>
Deductions from patient service revenues		
Provisions for doubtful accounts ...	1,798,933	1,817,341
Contractual adjustments	5,163,798	3,489,228
	<u>6,962,731</u>	<u>5,306,569</u>
NET PATIENT SERVICE REVENUES	19,835,308	18,226,710
Other operating revenues		
Cafeteria sales	213,784	195,963
Miscellaneous	15,653	15,890
	<u>229,437</u>	<u>211,853</u>
TOTAL OPERATING REVENUES	20,064,745	18,438,563
Operating expenses		
Nursing services	5,625,610	5,439,412
Other professional services	3,986,382	3,552,252
General services	2,953,178	2,818,799
Administrative services	3,964,171	3,474,865
Provision for depreciation	1,494,771	1,167,281
Interest and amortization of bond financing expenses	1,659,200	1,610,396
TOTAL OPERATING EXPENSES	19,683,312	18,063,005
GAIN FROM OPERATIONS..	381,433	375,558

(Continued on next page)

STATEMENTS OF REVENUES AND EXPENSES - Continued
GUERNSEY MEMORIAL HOSPITAL

	Year Ended December 31	
	1985	1984
Nonoperating revenues		
Interest earnings on funds held by trustee	244,681	527,420
Other, principally other investment earnings	398,152	245,231
	<u>642,833</u>	<u>772,651</u>
EXCESS OF REVENUES OVER EXPENSES BEFORE EXTRAORDINARY ITEM	1,024,266	1,148,209
EXTRAORDINARY ITEM		
Loss on debt extinguishment - Note C	672,581	
EXCESS OF REVENUES OVER EXPENSES	<u>\$ 351,685</u>	<u>\$ 1,148,209</u>

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS

NOTE C—LONG-TERM LIABILITIES (Continued)

In February 1985 the City issued \$15,375,000 Hospital Improvement Revenue Refunding Bonds (1985 Bonds). The proceeds of this bond issue were used to defease the 1982 and 1972 Bonds. In connection with the issuance of the 1985 Bonds the City and the Hospital executed a new lease agreement. Pursuant to this lease agreement substantially all of the Hospital facilities are leased from the City and pledged as security for repayment of the 1985 Bonds. Annual rentals under the terms of the lease agreement are equal to the debt service requirements of the 1985 Bonds. A provision of this lease grants an option to the Hospital to purchase the facilities for a nominal sum after provision has been made to retire the 1985 Bonds.

The defeasance of the 1982 and 1972 Bonds will allow the Hospital to significantly reduce its debt service requirements over the next 28 years. However, for accounting purposes the Hospital has recorded an extraordinary loss of \$672,581, related principally to the write-off of, the unamortized bond financing costs of the 1982 and 1972 bonds, in its 1985 financial statements. The third-party reimbursement effect of the extraordinary loss will be reported in the period the amounts are received.

The 1985 Bonds are due in annual installments ranging from \$400,000 on December 1, 1986 to \$775,000 on December 1, 1994, with interest at 6.5% to 10.0% (payable semi-annually) and (through mandatory sinking fund requirements) in annual installments thereafter ranging from \$855,000 on December 1, 1995 to \$1,715,000 on December 1, 2002, with interest at 10.5% (payable semi-

annually). The 1985 Bonds maturing in each of the years 1986 to 1990 amount to \$400,000, \$430,000, \$465,000, \$500,000, and \$540,000, respectively.

The 1985 Bonds due December 1, 1986 through December 1, 1994 are not redeemable prior to their respective maturities. The 1985 Bonds maturing on or after December 1, 1995, are redeemable on any interest payment date not earlier than December 1, 1995 at redemption prices ranging from 103% of principal amount at that date to 100% on or after December 1, 2001 plus accred interest.

In addition the Hospital is required to maintain specified balances in special funds held by the trustee for the 1985 Bonds. Substantially all gross receipts of the Hospital are pledged as collateral against retirement of the 1985 Bonds.

Notes payable carry interest rates of 13.75% and require principal payments each of the years 1986 through 1990 approximating \$49,000, \$56,200, \$64,500, \$74,000, and \$20,000, respectively. Certain data processing equipment has been pledged as security for repayment of the notes.

Interest costs incurred on the above long-term debt obligations approximated \$1,559,000 in 1984 of which \$112,000 was capitalized in 1984 as part of the cost of related construction projects. The amount of interest capitalized was reduced by \$20,000 in 1984 for interest earned on certain unexpended proceeds of the 1982 Bonds.

{Exhibit P-29}

APB Opinion No. 26

Early Extinguishment of Debt

STATUS

Issued: October 1972

Effective Date: For transactions on or after
January 1, 1973Affects: Supersedes ARB 43, Chapter 15 and footnotes 1
and 2

Supersedes APB 6, paragraph 19

Affected by: Paragraphs 2 and 3(a) amended by FAS 15
 Paragraph 2 amended by FAS 71
 Paragraph 2 superseded by FAS 76
 Paragraph 2 amended by FAS 84
 Paragraph 3(a) superseded by FAS 76
 Paragraph 3(c), 19, and 21 amended by
 FAS 76
 Paragraph 20 amended by APB 30
 Paragraph 20 amended by FAS 4

APB Opinion No. 26

Early Extinguishment of Debt

INTRODUCTION

1. Debt is frequently extinguished in various ways before its scheduled maturity. Generally, the amount paid upon reacquisition of debt securities will differ from the net carrying amount of the debt at that time. This Opinion expresses the views of the Accounting Principles Board regarding the appropriate accounting for that difference.

2. *Applicability.* This Opinion applies to the early extinguishment of all kinds of debt. It supersedes Chapter 15 of ARB No. 43 and Paragraph 19 of APB Opinion No. 6. However, this Opinion does not apply to debt that is converted pursuant to the existing conversion privileges of the holder. Moreover, it does not alter the accounting for convertible debt securities described in APB Opinion No. 14. This Opinion applies to regulated companies in accordance with the provisions of the Addendum to APB Opinion No. 2, *Accounting for the "Investment Credit,"* 1962.

3. *Definitions.* Several terms are used in this Opinion as follows:

- a. *Early extinguishment* is the reacquisition of any form of debt security or instrument before its scheduled maturity except through conversion by the holder, regardless of whether the debt is viewed as terminated or is held as so-called "treasury bonds." All open-market or mandatory reacquisitions of debt securities to meet sinking fund requirements are early extinguishments.
- b. *Net carrying amount* of debt is the amount due at maturity, adjusted for unamortized premium, discount, and cost of issuance.

- c. *Reacquisition price* of debt is the amount paid on early extinguishment, including a call premium and miscellaneous costs of reacquisition. If early extinguishment is achieved by a direct exchange of new securities, the reacquisition price is the total present value of the new securities.
- d. *Difference* as used in this Opinion is the excess of the reacquisition price over the net carrying amount or the excess of the net carrying amount over the reacquisition price.

DISCUSSION

4. *Current practice.* Early extinguishment of debt is usually achieved in one of three ways: use of existing liquid assets, use of proceeds from issuance of equity securities, and use of proceeds from issuing other debt securities. The replacement of debt with other debt is frequently called refunding.

5. Differences on nonrefunding extinguishments are generally treated currently in income as losses or gains. Three basic methods are generally accepted to account for the differences on refunding transactions:

- a. Amortization over the remaining original life of the extinguished issue
- b. Amortization over the life of the new issue
- c. Recognition currently in income as a loss or gain.

Each method has been supported in court decisions, in rulings of regulatory agencies, and in accounting literature.

6. *Amortization over life of old issue.* Some accountants believe that the difference on refunding should be amortized over the remaining original life of the extinguished

issue. In effect, the difference is regarded as an adjustment of the cash cost of borrowing that arises from obtaining another arrangement for the unexpired term of the old agreement. Therefore, the cost of money over the remaining period of the original issue is affected by the difference that results upon extinguishment of the original contract. Early extinguishment occurs for various reasons, but usually because it is financially advantageous to the issuer, for example, if the periodic cash interest outlay can be reduced for future periods. Accordingly, under this view the difference should be spread over the unexpired term of the original issue to obtain the proper periodic cost of borrowed money. If the maturity date of the new issue precedes the maturity date of the original issue, a portion of the difference is amortized over the life of the new debt and the balance of the difference is recognized currently in income as a loss or gain.

7. *Amortization over life of new issue.* Some accountants believe that the difference on refunding should be amortized over the life of the new issue if refunding occurs because of lower current interest rates or anticipated higher interest rates in the future. Under this view, the principal motivation for refunding is to establish a more favorable interest rate over the term of the new issue. Therefore, the expected benefits to be obtained over the life of the new issue justify amortization of the difference over the life of the new issue.

8. *Recognition currently in income.* Some accountants believe a difference on refunding is similar to the difference on other early extinguishments and should be recognized currently in income in the period of the extinguishment. This view holds that the value of the old debt has changed over time and that paying the call price or

current market value is the most favorable way to extinguish the debt. The change in the market value of the debt is caused by a change in the market rate of interest, but the change has not been reflected in the accounts. Therefore, the entire difference is recorded when the specific contract is terminated because it relates to the past periods when the contract was in effect. If the accountant had foreseen future events perfectly at the time of issuance, he would have based the accounting on the assumption that the maturity value of the debt would equal the reacquisition price. Thus, no difference upon early extinguishment would occur because previous periods would have borne the proper interest expense. Furthermore, a call premium necessary to eliminate an old contract and an unamortized discount or premium relate to the old contract and cannot be a source of benefits from a new debt issue. For example, a larger (or smaller) coupon rate could have been set on the old issue to avoid an unamortized discount (or premium) at issuance. When such debt originally issued at par is refunded, few accountants maintain that some portion of past interest should be capitalized and written off over the remaining life of the old debt or over the life of the new debt.

9. Another argument in favor of current recognition of the difference as gain or loss is also related to market forces but is expressed differently. If debt is callable, the call privilege is frequently exercised when the market value of the bonds as determined by the current yield rate exceeds the call price. A loss or gain is recognized on extinguishing the debt because an exchange transaction occurs in which the call or current market value of the debt differs from its net carrying amount. For example, the market value of the debt ordinarily rises as the market rate of interest falls. If market values were recorded as the

market rate of interest fluctuates, the changes in the market value of the debt would have been recorded periodically as losses or gains. The bond liability would not exceed the call price.

10. On the other hand, some accountants holding views opposing current recognition of the difference in income believe that recognizing the difference as gains or losses may induce a company to report income by borrowing money at high rates of interest in order to pay off discounted low-rate debt. Conversely, a large potential charge to income may discourage refunding even though it is economically desirable; the replacement of high cost debt with low cost debt may result in having to recognize a large loss. Thus, a company may shower higher current income in the year of extinguishment while increasing its economic cost of debt and lower current income while decreasing its economic cost of debt. For these reasons, these accountants favor deferral.

11. *Extinguishment of convertible debt.* Accountants have expressed differing views regarding accounting for the extinguishment of convertible debt. In APB Opinion No. 14, which is directed in part to accounting for convertible debt at time of issue, the Board concluded that no portion of the proceeds from the issuance of the types of convertible debt securities defined in the Opinion should be accounted for as attributable to the conversion feature. In reaching that conclusion, the Board placed greater weight on the inseparability of the debt and conversion option and less weight on practical difficulties. The Board emphasized that a convertible debt security is a complex hybrid instrument bearing an option the alternative choices of which cannot exist independently of one another. The holder ordinarily does not sell one right and

retain the other. Furthermore, the two choices are mutually exclusive; the holder cannot exercise the option to convert unless he foregoes the right to redemption, and vice versa. Therefore, APB Opinion No. 14 implies that (except for conversion) a difference on extinguishing convertible debt needs to be recognized in the same way as a difference on extinguishment of debt without conversion features.

12. The various views expressed on how to account for the extinguishment of convertible debt to some extent reflect the same attitudes as to the nature of the debt at time of issue as were considered in APB Opinion No. 14. Thus, some accountants believe that a portion of the proceeds at issuance is attributable to the conversion feature. If the convertible debt is later extinguished, the initial value of the conversion feature should then be recorded as an increase in stockholders' equity. The balance of the difference would, under that view of the transaction, be a gain or loss in income of the period of extinguishment.

13. Some accountants maintain that the intent of issuing convertible debt is to raise equity capital. A convertible debt is therefore in substance an equity security, and all the difference on extinguishing convertible debt should be an increase or decrease of paid-in capital.

14. Another view is that the market price that gives rise to the difference reflects both the level of interest rates on debt and the prices of the related common stock or both. Those expressing this view believe that if the effects of these factors can be identified at the time of extinguishment, the difference attributable to the interest rate should be accounted for as gain or loss in income, and that the difference attributable to the market price of the issuer's

common stock should be accounted for as an increase or decrease in paid-in capital.

15. Some accountants believe that the accounting for a difference on extinguishment of convertible debt depends on the nature of the security at the time of extinguishment. Events after time of issue may provide evidence that a convertible debt is either still debt in substance or equity in substance. Under this view the purchase price on extinguishment provides the best evidence as to whether the security is essentially debt or equity. Convertible debt that is selling below the call or redemption price at time of extinguishment is essentially debt; the difference should be a gain in current income. Moreover, if convertible debt has a coupon rate that exceeds the current market rate of interest and clearly causes the issue to trade at a premium as a debt instrument, the difference on extinguishment should be a loss in current income. On the other hand, if convertible debt is selling above the call or redemption price because of the conversion privilege, it is essentially a common stock. In effect, market forces have transformed a debt instrument into an equity security, and the extinguishment provides an explicit transaction to justify recognizing that the convertible debt is in substance a common stock equivalent. Those who hold this view believe that accounting should report the substance of the transaction rather than its form; convertible debt need not be converted into common stock to demonstrate that the extinguishment transaction is equivalent to a purchase of common stock for retirement.

16. *Economic nature of extinguishment.* In many respects the essential economics of the decision leading to the early extinguishment of outstanding debt are the same, regardless of whether such debt is extinguished via the use

of the existing liquid assets, new equity securities, or new debt. That is, the decision favoring early extinguishment usually implies that the net present value of future cash inflows and outflows is maximized by extinguishing the debt now rather than by letting it run to maturity. The savings may be in lower cash interest costs on a new debt issue, in increased earnings per share of common stock if the assets are not earning the interest rate on the outstanding debt, or in some other form. The essential event is early extinguishment. Under this view, the difference is associated with extinguishing the existing debt and is accounted for the same regardless of how extinguishment is accomplished.

17. To illustrate that view, assume that three firms each have long-term debt outstanding with ten years remaining to maturity. The first firm may have excess cash and no investment opportunities that earn a rate of return higher than the cash savings that would ensue from immediately extinguishing the debt. The second firm may wish to replace the debt with a similar issue bearing a lower coupon rate. The third firm may have excessive debt and may want to replace the debt with a new issue of common stock. The underlying reason for the early extinguishment in all three cases is to obtain a perceived economic advantage. The relevant comparison in the replacement of debt with other debt is with the costs of other debt. The comparison in other cases is with other means of financing. The means by which the debt is extinguished have no bearing on how to account for the loss or gain.

OPINION

18. The following conclusions of the Board are based primarily on the reasoning in paragraphs 8, 9, 11, 16, and 17.

19. *Reduction of alternatives.* The Board concludes that all extinguishments of debt before scheduled maturities are fundamentally alike. The accounting for such transactions should be the same regardless of the means used to achieve the extinguishment.

20. *Disposition of amounts.* A difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains and identified as a separate item.¹ The criteria in APB Opinion No. 9 should be used to determine whether the losses or gains are ordinary or extraordinary items. Gains and losses should not be amortized to future periods.

21. *Convertible debt.* The extinguishment of convertible debt before maturity does not change the character of the security as between debt and equity at that time. Therefore, a difference between the cash acquisition price of the debt and its net carrying amount should be recognized currently in income in the period of extinguishment as losses or gains.

EFFECTIVE DATE

22. This Opinion shall be effective for all extinguishments of debt occurring on or after January 1, 1973. Extinguishment transactions are considered to be terminated events similar to that set forth in paragraph 16 of APB Opinion No. 20 and as such, extinguishments that were

¹ If upon extinguishment of debt, the parties also exchange unstated (or stated) rights or privileges, the portion of the consideration exchanged allocable to such unstated (or stated) rights or privileges should be given appropriate accounting recognition. Moreover extinguishment transactions between related entities may be in essence capital transaction.

previously recorded in fiscal years ending before January 1, 1973 should not be adjusted. However, the accounting for refunding transactions that have been previously reported in the fiscal year in which December 31, 1972 occurs may be retroactively restated to comply with the provisions of this Opinion.

The Opinion entitled "Early Extinguishment of Debt" was adopted by the assenting votes of fifteen members of the Board, of whom three, Messrs. Cummings, Ferst, and Gellein, assented with qualification. Messrs. Defliese, Watt, and Wear dissented.

Messrs. Cummings and Ferst assent to the issuance of this Opinion because it will reduce alternatives in accounting for extinguishments of long-term debt which are fundamentally alike. They object, however, to the conclusion in paragraph 21 that extinguishment of convertible debt gives rise to an income charge for the entire difference between the acquisition price and its carrying amount under all circumstances. In their view when convertible debt is traded at amounts which are clearly attributable to the value of the securities into which it is convertible, the acquisition of such debt by the issuing company is in substance an acquisition of its treasury stock. Paragraph 21 mandates the unnecessary process of first converting the debt and then acquiring the stock in order to reflect the financial reality inherent in the transaction.

Mr. Gellein assents to issuance of the Opinion but disagrees with the conclusion expressed in paragraph 18 that all extinguishments of debt before scheduled maturities are fundamentally alike. He believes that some debt retirements which are accompanied by concurrent borrowings have economic purposes and results different from other debt retirements, and that the accounting should in these

limited cases recognize these differences. Where a concurrent borrowing and retirement is planned, for example, to take advantage of a relatively low market rate of interest, or to avoid an anticipated increase, he believes that there is in substance a substitution of debt and that the "difference" between the reacquisition price and the net carrying amount of the retired debt should be charged or credited, as the case may be, to income over the remaining term of the retired debt. He believes that in such a situation the difference, whether charge or credit, arises from an economic circumstance and an action the result of which is to cause the periodic interest expense to be virtually unchanged during the remaining life of the retired debt. Amortizing the "difference" over the remaining life of the retired debt will show that result; the accounting recommended in paragraph 19 will not.

Mr. Defliese dissents to this Opinion because it fails to require recognition of the economic effects associated with an early extinguishment of debt designed to yield a profit. In his view such a payment, whether from borrowed funds (debt refunding) or from working capital (equity refunding), is essentially in every case a refunding at a higher cost of money (over the remaining original term) than that of the debt being prepaid, equivalent to an arbitrage with a predetermined net profit consisting of the *difference* between the discount from par and the future increased interest differential. He believes that omission of a provision for this added interest cost overstates the profit in the year of prepayment and shifts the interest burden to future periods. When the added cost is not known, or cannot be reasonably estimated, the entire discount should be allocated ratably over the remaining original term to offset such cost, in which case the net profit is spread over the remaining term. Similarly, when debt is refunded at a pre-

mium in order to take advantage of lower current or future rates, the premium should be deferred and charged appropriately to the periods benefited.

Mr. Watt dissents to this Opinion for the reasons set forth in paragraphs 6 and 10, because it requires gain or loss to be recognized currently in income of a difference between the reacquisition price and the net carrying amount of the extinguished debt in a refunding situation. He also dissents, for the reason set forth in paragraph 15, because it requires a loss to be recognized on the retirement of a convertible debt that is obviously trading on its common stock characteristics. To him this Opinion is a classic example of narrowing alternative accounting principles in a limited area to a point where the use of different accounting principles to accommodate entirely different circumstances calling for different results has now been proscribed.

Mr. Wear dissents to this Opinion because, in his view, it does not develop a persuasive and convincing argument that all extinguishments of debt before scheduled maturities are fundamentally alike.

He believes there are important differences in refunding situations, for the reasons described in paragraph 6, and where convertible debt is involved, for the reasons set forth in paragraph 15.

NOTES

Opinions of the Accounting Principles Board present the conclusions of at least two-thirds of the members of the Board, which is the senior technical body of the Institute authorized to issue pronouncements on accounting principles.

Board Opinions are considered appropriate in all circumstances covered but need not be applied to immaterial items.

Covering all possible conditions and circumstances in an Opinion of the Accounting Principles Board is usually impracticable. The substance of transactions and the principles, guides, rules, and criteria described in Opinions should control the accounting for transactions not expressly covered.

Unless otherwise stated, Opinions of the Board are not intended to be retroactive.

Council of the Institute has resolved that Institute members should disclose departures from Board Opinions in their reports as independent auditors when the effect of the departures on the financial statements is material or see to it that such departures are disclosed in notes to the financial statements and, where practicable, should disclose their effects on the financial statements (Special Bulletin, Disclosure of Departures from Opinions of the Accounting Principles Board, October 1964). Members of the Institute must assume the burden of justifying any such departures.

Accounting Principles Board (1972)

Philip L. Defliese, *Chairman*
Donald J. Bevis
Albert J. Bows
Milton M. Broeker
Leo E. Burger
Joseph P. Cummings
Robert L. Ferst
Oscar Gellein
Newman T. Halvorson

Robert Hampton, III
Donald J. Hayes
Charles B. Hellerson
Charles T. Horngren
Louis M. Kessler
David Norr
George C. Watt
Allan Wear
Glenn A. Welsch

[EXHIBIT P-32]

COMPARATIVE SCHEDULE
ANNUAL DEBT SERVICE
GUERNSEY MEMORIAL HOSPITAL

Year Ending December 1,	1985 Bonds			1972 and 1982 Bonds				Total Principal and Interest
	Interest Due	Principal Due	Principal and Interest Due	Interest Due		Principal Due		
				1972 Bonds	1982 Bonds	1972 Bonds	1982 Bonds	
1985	\$ 1,275,094	\$ 115,000	\$ 1,390,094	\$ 364,700	\$ 1,286,250	\$ 25,000		\$ 1,675,950
1986	1,522,638	400,000	1,922,638	363,650	1,286,250	325,000		1,974,900
1987	1,494,638	430,000	1,924,638	340,900	1,286,250	350,000		1,977,150
1988	1,462,388	465,000	1,927,388	316,400	1,286,250	375,000		1,977,650
1989	1,425,188	500,000	1,925,188	290,150	1,286,250	400,000		1,976,400
1990	1,382,688	540,000	1,922,688	262,150	1,286,250	430,000		1,978,400
1991	1,334,088	590,000	1,924,088	232,050	1,286,250	465,000		1,983,300
1992	1,279,512	650,000	1,929,512	199,500	1,286,250	490,000		1,975,750
1993	1,217,762	705,000	1,922,762	165,200	1,286,250	530,000		1,981,450
1994	1,149,025	775,000	1,924,025	128,100	1,286,250	570,000		1,984,350
1995	1,071,525	855,000	1,926,525	88,200	1,286,250	610,000		1,984,450
1996	981,750	940,000	1,921,750	45,500	1,286,250	650,000		1,981,750
1997	883,050	1,045,000	1,928,050		1,286,250		\$ 370,000	1,656,250
1998	773,325	1,150,000	1,923,325		1,241,850		415,000	1,656,850
1999	652,575	1,275,000	1,927,575		1,192,050		465,000	1,657,050
2000	518,700	1,405,000	1,923,700		1,136,250		520,000	1,656,250
2001	371,175	1,555,000	1,926,175		1,073,850		580,000	1,653,850
2002	207,900	1,715,000	1,922,900		1,004,250		650,000	1,654,250
2003	27,825	265,000	292,825		926,250		410,000	1,336,250
2004					875,000		465,000	1,340,000
2005					816,875		520,000	1,336,875
2006					751,875		585,000	1,336,875
2007					678,750		660,000	1,338,750
2008					596,250		745,000	1,341,250
2009					503,125		835,000	1,338,125
2010					398,750		940,000	1,338,750
2011					281,250		1,060,000	1,341,250
2012					148,750		1,190,000	1,338,750
	<u>\$19,030,846</u>	<u>\$15,375,000</u>	<u>\$34,405,846</u>	<u>\$2,796,500</u>	<u>\$28,346,375</u>	<u>\$5,220,000</u>	<u>\$10,410,000</u>	<u>\$46,772,875</u>

[EXHIBIT P-33]

CALCULATION OF LOSS ON EXTINGUISHMENT OF DEBT
GUERNSEY MEMORIAL HOSPITAL
December 31, 1985

Purchase of escrow securities	<u>\$16,011,200</u>
NET REACQUISITION	
PRICE	16,011,200
Old debt:	
1982 Bonds outstanding	10,410,000
1972 Bonds outstanding	5,220,000
Unamortized financing cost	(709,499)
Interest expense payable	<u>418,118</u>
NET CARRYING AMOUNT	
OF OLD DEBT	<u>15,338,619</u>
LOSS ON	
EXTINGUISHMENT OF	
DEBT	<u>\$ 672,581</u>

[INTERMEDIARY'S SUPPLEMENTAL POSITION PAPER]**II. THE LOSS AND THE ADVANCE REFUNDING**

A) Prior to the refinancing, the Provider had the following debt outstanding:

	<u>1972 Bonds</u>	<u>1982 Bonds</u>
Original Prin.	\$7,600,000	\$10,410,000
Outstanding Prin. (Feb. '85)	5,220,000	10,410,000
Interest Rates	5.25 to 6%	12.0 to 12.5%
Term	to 1996	to 2012
Early Call*	N/A	1992
Source:	Exh. 25	Exh. 26

* Under the refinancing, the Intermediary believes that the 1972 bonds were to be paid off at their scheduled maturity without regard to any early call date. The 1982 bonds would be paid at the 1992 call date.

[INTERMEDIARY'S EXHIBIT M]

GUERNSEY MEMORIAL HOSPITAL
Amortization of Loss on Early Extinguishment of Debt
12-31-85

Period	(1) Interest Expense Refunded Interest	(2) Refunding Series 1985	(3) Investment Income on Escrow Funds	(4) = (1 + 2 - 3) Net Allowable Interest Expense	(5) Amortization of Series Old Finance Costs	(6) Amortization of Series 1985 Finance Costs	(7) Call Premium	(8) = (4 + 5 + 6 + 7) Total Allowable Expenses After Refunding	(9) = (2 + 6) Total Actual Expense After Refunding	(10) = (8 - 9) Medicare Work Sheet A - B Adjustment	
1985	1,371,738	1,401,981	1,453,679	1,320,039	100,503	69,736		1,490,278	1,471,717	18,561	
1986	1,648,004	1,520,304	1,692,532	1,475,776	101,268	67,908		1,644,952	1,588,212	56,740	
1987	1,625,108	1,491,951	1,664,361	1,452,699	99,773	65,943		1,618,415	1,557,891	60,521	
1988	1,600,463	1,459,288	1,612,617	1,447,134	98,171	63,818		1,609,123	1,523,106	86,017	
1989	1,574,067	1,421,646	1,585,879	1,409,834	96,262	61,532		1,567,628	1,483,176	84,450	
1990	1,545,892	1,378,638	1,525,615	1,398,915	94,624	59,065		1,552,604	1,437,703	114,901	
1991	1,515,588	1,329,540	1,508,787	1,336,340	92,640	56,369		1,485,349	1,385,909	99,440	
1992	1,375,704	1,274,366	1,359,530	1,290,540	10,080	53,398	312,300	1,666,318	1,327,764	338,304	
1993	162,108	1,212,034	233,234	1,140,908	7,816	50,177		1,198,901	1,262,211	- 63,310	
1994	124,775	1,142,567	182,652	1,084,690	5,381	46,635		1,136,706	1,189,202	- 52,496	
1995	84,642	1,064,044	126,104	1,022,581	2,776	42,728		1,068,085	1,106,772	- 38,687	
1996	41,708	973,525	63,240	951,994	0	38,432		990,426	1,011,957	- 21,531	
1997	0	873,906	0	873,906	0	33,657		907,563	907,563	0	
1998	0	763,262	0	763,262	0	28,401		791,663	791,663	0	
1999	0	641,419	0	641,419	0	22,575		663,994	663,994	0	
2000	0	506,406	0	506,406	0	16,154		522,560	522,560	0	
2001	0	357,569	0	357,569	0	9,048		366,617	366,617	0	
2002	0	204,488	0	204,488	0	1,211		205,699	205,699	0	
2003	0	13,913	0	13,913	0			13,913	13,913	0	
2004	0		0	0	0			0	0	0	
2005	0		0	0	0			0	0	0	
2006	0		0	0	0			0	0	0	
2007	0		0	0	0			0	0	0	
2008	0		0	0	0			0	0	0	
2009	0		0	0	0			0	0	0	
2010	0		0	0	0			0	0	0	
2011	0	0	0	0	0			0	0	0	
2012	0	0	0	0	0			0	0	0	
2013	0	0	0	0	0			0	0	0	
2014	0	0	0	0	0			0	0	0	
2015	0	0	0	0	0			0	0	0	
2016	0	0	0	0	0			0	0	0	
2017	0	0	0	0	0	0		0	0	0	
2018	0	0	0	0	0	0		0	0	0	
2019	0	0	0	0	0	0		0	0	0	
2020	0	0	0	0	0	0	0	0	0	0	
TOTAL	12,669,796	19,030,847	13,008,230	18,692,413	709,293	786,787	312,300	20,500,793	19,817,634	683,159	672,581

**[INTERMEDIARY'S EXHIBIT N]
COMMUNITY MUTUAL INSURANCE COMPANT
ANALYSIS OF BOND DEFEASANCE**

**GUERNSEY MEMORIAL HOSPITAL
INTEREST EXPENSE**

Period	Refunded Interest Exp 1972	Refunded Interest Exp 1982	Paid Total	Beginning Accrual	Ending Accrual	Previously Expended	Total	
1985	364,700	1,286,250	1,650,950	137,579	137,492	279,125	1,371,738	1,681,254
1986	363,650	1,286,250	1,649,900	137,492	135,596		1,648,004	
1987	340,900	1,286,250	1,627,150	135,596	133,554		1,625,108	
1988	316,400	1,286,250	1,602,650	133,554	131,367		1,600,463	
1989	290,150	1,286,250	1,576,400	131,367	129,033		1,574,067	
1990	262,150	1,286,250	1,548,400	129,033	126,525		1,545,892	
1991	232,050	1,286,250	1,518,300	126,525	123,813		1,515,588	
1992	199,500	1,286,250	1,485,750	123,813	13,767		1,375,704	
1993	165,200		165,200	13,767	10,675		162,108	
1994	128,100		128,100	10,675	7,350		124,775	
1995	88,200		88,200	7,350	3,792		84,642	
1996	45,500		45,500	3,792	0		41,708	
1997			0	0	0		0	
1998			0	0	0		0	
1999			0	0	0		0	
2000			0	0	0		0	
2001			0	0	0		0	
2002			0	0	0		0	
2003			0	0	0		0	
2004			0	0	0		0	
2005			0	0	0		0	
2006			0	0	0		0	
2007			0	0	0		0	
2008			0	0	0		0	
2009			0	0	0		0	
2010			0	0	0		0	
2011			0	0	0		0	
2012			0	0	0		0	
2013			0	0	0		0	
2014			0	0	0		0	
2015			0	0	0		0	
2016			0	0	0		0	
2017			0	0	0		0	
2018			0	0	0		0	
2019			0	0	0		0	
2020			0	0	0		0	
	2,796,500	10,290,000	13,086,500	1,090,542	952,963		12,669,796	

**GUERNSEY MEMORIAL HOSPITAL
INTEREST INCOME**

**COMMUNITY MUTUAL INSURANCE COMPANY
ANALYSIS OF BOND DEFEASANCE**

Period	June Receipts	INCOME ON OBLIGATIONS		Total Receipts	Beginning Accrual	Ending Accrual	Total Interest Income
		December Receipts	Open Market Securities				
1985	409,559.54	791,785.98	111,110	1,312,456		141,223	1,453,679
1986	791,785.98	791,785.98	111,110	1,694,682	141,223	139,074	1,694,532
1987	778,889.06	778,889.06	111,110	1,668,888	139,074	134,547	1,664,361
1988	763,376.95	763,376.95	87,805	1,614,559	134,547	132,604	1,612,617
1989	763,376.95	763,376.95	64,500	1,591,254	132,604	127,229	1,585,879
1990	763,376.95	763,376.95		1,526,754	127,229	126,090	1,525,615
1991	756,541.11	756,541.11		1,513,082	126,090	121,795	1,508,787
1992	731,091.08	730,450.29		1,461,541	121,795	19,784	1,359,530
1993	118,704.14	118,704.14		237,408	19,784	15,610	233,234
1994	93,660.20	93,660.20		187,320	15,610	10,941	182,652
1995	65,648.31	65,648.31		131,297	10,941	5,749	126,104
1996	34,494.33	34,494.33		68,989	5,749	0	63,240
1997				0			
1998				0			
1999				0			
2000				0			
2001				0			
2002				0			
2003				0			
2004				0			
2005				0			
2006				0			
2007				0			
2008				0			
2009				0			
2010				0			
2011				0			
2012				0			
2013				0			
2014				0			
2015				0			
2016				0			
2017				0			
2018				0			
2019				0			
2020				0			
TOTAL	6,070,505	6,452,090	485,635	13,008,230	974,648	974,648	13,008,230

All income on investments reflect accrued interest for the month of December, per HCFA-15 section 233.

**COMMUNITY MUTUAL INSURANCE COMPANY
ANALYSIS OF BOND DEFEASANCE**

**GUERNSEY MEMORIAL HOSPITAL
AMORTIZATION OF FINANCING COST**

Period	1972 Issue	1982 Issue	Previously Expenses	Total
1985	22,189	80,467	-2,153	100,503
1986	20,801	80,467		101,268
1987	19,306	80,467		99,773
1988	17,704	80,467		98,171
1989	15,795	80,467		96,262
1990	14,157	80,467		94,624
1991	12,173	80,467		92,640
1992	10,080	0		10,080
1993	7,816	0		7,816
1994	5,381	0		5,381
1995	2,776	0		2,776
1996		0		0
1997		0		0
1998		0		0
1999		0		0
2000		0		0
2001		0		0
2002		0		0
2003		0		0
2004		0		0
2005		0		0
2006		0		0
2007		0		0
2008		0		0
2009		0		0
2010		0		0
2011		0		0
2012		0		0
2013		0		0
2014		0		0
2015		0		0
2016		0		0
2017		0		0
2018		0		0
2019		0		0
2020		0		0
TOTAL	148,178	563,268	-2,153	709,293

**COMMUNITY MUTUAL INSURANCE COMPANY
ANALYSIS OF BOND DEFEASANCE**

Period	Bonds Retired	Bonds Outstanding Beg of Year	Amortization Per Year	Remaining Unamortized Amount	Amortization Expense
1982	0				0
1983	0				0
1984	0			563,268	0
1985	0	10,410,000	0.142857	482,801	80,467
1986	0	10,410,000	0.142857	402,334	80,467
1987	0	10,410,000	0.142857	321,867	80,467
1988	0	10,410,000	0.142857	241,401	80,467
1989	0	10,410,000	0.142857	160,934	80,467
1990	0	10,410,000	0.142857	80,467	80,467
1991	0	10,410,000	0.142857	0	80,467
1992	10,410,000	0	0.000000	0	0
1993	0	0	0.000000	0	0
1994	0	0	0.000000	0	0
1995	0	0	0.000000	0	0
1996	0	0	0.000000	0	0
1997	0	0	0.000000	0	0
1998	0	0	0.000000	0	0
1999	0	0	0.000000	0	0
2000	0	0	0.000000	0	0
2001	0	0	0.000000	0	0
2002	0	0	0.000000	0	0
2003	0	0	0.000000	0	0
2004	0	0	0.000000	0	0
2005	0	0	0.000000	0	0
2006		0	0.000000	0	0
2007		0	0.000000	0	0
2008		0	0.000000	0	0
2009		0	0.000000	0	0
2010		0	0.000000	0	0
2011		0	0.000000	0	0
2012		0	0.000000	0	0
2013		0	0.000000	0	0
2014		0	0.000000	0	0
2015		0	0.000000	0	0
2016		0	0.000000	0	0
2017		0	0.000000	0	0
2018		0	0.000000	0	0
2019		0	0.000000	0	0
2020		0	0.000000	0	0
	10,410,000	72,870,000	1	2,253,072	563,268

NEW ISSUE

Rating: Standard & Poor's: BBB(p)

In the opinion of Bond Counsel, under existing law interest on the 1985 Bonds is exempt from federal income tax and Ohio corporate franchise tax; interest and any profit made on the sale of the 1985 Bonds are exempt from Ohio personal income tax and municipal income taxes in Ohio; and the 1985 Bonds are exempt from Ohio intangible property taxes. (See "Tax Exemption" at page 38 herein.)



OFFICIAL STATEMENT RELATING TO THE ORIGINAL ISSUANCE OF

45 936

\$15,375,000

CITY OF CAMBRIDGE, OHIO

HOSPITAL IMPROVEMENT REVENUE REFUNDING BONDS, SERIES 1985 (Guernsey Memorial Hospital Project)

Dated: February 1, 1985

Due: Serially December 1, 1985
through December 1, 1994
and on December 1, 2003

The 1985 Bonds are issuable only as fully registered bonds, without coupons, in denominations of \$5,000 and whole multiples thereof. Interest is payable semiannually on June 1 and December 1, commencing June 1, 1985, and will be mailed to holders of the 1985 Bonds. Principal is payable as set forth below at the corporate trust office of the Trustee, currently BancOhio National Bank, Columbus, Ohio.

Principal of, premium, if any, and interest on the 1985 Bonds are payable primarily from rentals paid to the City of Cambridge, Ohio, by Guernsey Memorial Hospital, as lessee and guarantor. Neither the general resources, the full faith and credit, nor the taxing power of the City, the State, or any political subdivision are pledged to the payment of the principal of and premium, if any, and interest on the 1985 Bonds, which are special obligations of the City.

MATURITY SCHEDULE

SERIAL 1985 BONDS

December 1	Principal Amount	Interest Rate	Price or Yield(1)	December 1	Principal Amount	Interest Rate	Price or Yield(1)
1985	\$115,000	6.50%	100%	1990	\$540,000	9.00%	100%
1986	400,000	7.00	100	1991	590,000	9.25	100
1987	430,000	7.50	100	1992	650,000	9.50	100
1988	465,000	8.00	100	1993	705,000	9.75	100
1989	500,000	8.50	100	1994	775,000	10.00	100

TERM 1985 BONDS

December 1	Principal Amount	Interest Rate	Price or Yield(1)
2003	\$10,205,000	10.50%	100%

(1) Plus accrued interest from February 1, 1985.

Redemption Prior to Maturity: The 1985 Bonds are callable for redemption, prior to maturity (1) in whole at any time and in part on any interest payment date, in each case on and after December 1, 1995, to retire the 1985 Bonds optionally, (2) in part on December 1 of each of the years 1995 through 2002, pursuant to sinking fund requirements, to retire mandatorily the 1985 Bonds maturing December 1, 2003, and (3) in whole at any time, or in part on any interest payment date, as a result of damage to, destruction or condemnation of the Leased Premises, and as a whole at any time if certain other events occur, all as set forth hereinafter and more specifically in the Indenture. (See "The 1985 Bonds—1985 Bond Redemption Prior to Maturity" at page 8 herein.)

The 1985 Bonds are offered, subject to prior sale, to withdrawal or to modification of the offer without any notice, when, as and if issued by the City and received by the Underwriters, subject to approval of certain legal matters relating to the issuance of the 1985 Bonds by Squire, Sanders & Dempsey, Bond Counsel. Certain legal matters will be passed upon for the issuance by Tribbie, Scott and Moorehead and by Bricker & Eckler, and for the Underwriters by Gingham & Christensen. A feasibility study, conducted by Ernst & Whinney, is included herein as Appendix II. The initial yield or offering price set forth above and concessions in transactions with securities dealers may be changed by the Underwriters. The 1985 Bonds are expected to be available for delivery in definitive form in Columbus, Ohio, on or about February 27, 1985.

The Ohio Company

McDonald & Company
Securities, Inc.

Dated February 7, 1985

INTRODUCTORY STATEMENT OF CERTAIN FACTORS

This introductory statement is subject in all respects to the more complete information appearing elsewhere in this Official Statement. The introductory statement is not to be read or used without reference to the entire Official Statement.

Risks: Since payment of the principal of and interest on the bonds described on the front page of this Official Statement (the "1985 Bonds") is dependent entirely on the revenues to be derived from the Leased Premises, as hereinafter described, certain risks are inherent in the payment of such principal and interest. Reference should be made to the Official Statement as a whole, and particularly to the section entitled "Bondholders' Risks" at page 39 herein, for a description of certain risks.

The City: The City of Cambridge, Ohio (the "Issuer" or "City") is a municipal corporation and a political subdivision organized and existing under the laws of the State of Ohio, and is authorized by such laws, among other things, to issue bonds for the acquisition, construction and improvement of hospital facilities, such as the Leased Premises, to lease such facilities to Ohio, non-profit corporations, such as Guernsey Memorial Hospital, and to issue bonds to refund obligations previously issued to pay the costs of such facilities.

The Hospital: Guernsey Memorial Hospital (the "Hospital") is a private, non-profit corporation organized under the laws of Ohio, which currently operates a 202-bed hospital located in and adjacent to the City of Cambridge, Ohio. (See "The Hospital" at page 10 herein.)

The Trustee: BancOhio National Bank (the "Trustee") is a national association organized under the laws of the United States of America and duly authorized to exercise corporate trust powers under the laws of the State of

Ohio, with its principal corporate trust offices located at 155 East Broad Street, Columbus, Ohio 43265.

The 1985 Bonds: 1985 Bonds in the aggregate principal of \$15,375,000 will be issued in the form of serial bonds and term bonds. 1985 Bonds are issuable only in fully registered form, in denominations of \$5,000 and whole multiples thereof. Semiannual interest at the rates set forth on the front page of this Official Statement is payable on June 1 and December 1, commencing June 1, 1985, until maturity or prior redemption. (See "The 1985 Bonds" at page 6 herein.)

The Existing Facilities, the Leased Real Property and the Leased Premises: The Hospital leases from the City and operates an existing 202-bed hospital facility and certain other property associated therewith (the "Existing Facilities") together with the approximately 12 acres of land upon which the Existing Facilities are situated (the "Leased Real Property"). (See "The Hospital—The Existing Facilities" at page 11 herein.) The Existing Facilities and the Leased Real Property are herein together called the "Leased Premises".

Purpose of the Financing: Proceeds from the sale of the 1985 Bonds, together with the Equity Contribution of the Hospital, will be used by the City to advance refund the City's outstanding Hospital Improvement First Mortgage Revenue Bonds, issued in 1972 (the "1972 Bonds") and its outstanding Hospital Improvement Mortgage Revenue Bonds, Series 1982 (Guernsey Memorial Hospital Project), issued in 1982 (the "1982 Bonds"), to fund the Debt Service Reserve Fund for the 1985 Bonds and to pay certain costs related to the issuance of the 1985 Bonds. (See "Estimated Sources and Uses of Funds" at page 6 herein.)

Security: The 1985 Bonds, together with any additional bonds ("Additional Bonds") hereafter issued on a parity with the 1985 Bonds, will be secured by (1) a Trust

Indenture dated as of February 1, 1985 (the "Indenture"), by and between the City and the Trustee, pursuant to which the City (i) grants to the Trustee a lien on and a security interest in Hospital Receipts, defined generally as all monies, investments and proceeds of investments received by the City or the Trustee from or in connection with the ownership, lease, operation, acquisition, construction, improvement, equipping or financing of the Leased Premises, including monies in the Special Funds (see "the Special Funds," below), less any reasonable and proper expenses of the City or state of operating, maintaining and repairing the Leased Premises, and (ii) assigns to the Trustee (subject to limited exceptions) its right, title and interest in and to the Lease dated as of February 1, 1985 (the "Lease") between the City and the Hospital, including the City's right to receive Basic Rent from the Hospital, and (2) a Guaranty Agreement dated as of February 1, 1985 (the "Guaranty") between the Hospital and the Trustee in which the Hospital unconditionally guarantees to the Trustee the payment of the principal of, premium, if any, and interest on the 1985 Bonds when due. (See "The 1985 Bonds—Security" at page 7 herein.)

In order to secure its obligation to pay Basic Rent and to comply with its other obligations under the Lease, the Hospital has granted the City a security interest in its Gross Revenues, which security interest has been assigned by the City to the Trustee in the Indenture. (See "The Lease—Pledge of Gross Revenues" at page 28 herein.)

The Hospital, under certain circumstances, may incur indebtedness ("Parity Debt"), secured by a security interest in the Hospital's Gross Revenues which is on a parity with the 1985 Bonds and any Additional Bonds. (See "The 1985 Bonds—Security" at page 7 herein and "The 1985 Bonds—Additional Bonds and Parity Debt" at page 8 herein).

The Special Funds: In accordance with the terms of the Indenture the City has created the Debt Service Fund, Debt Service Reserve Fund, Depreciation Reserve Fund, Hospital Revenue Fund, Surplus Fund, Administrative Expense Fund and Project Fund (together called the "Special Funds"), all of which Funds (except for the Hospital Revenue Fund) shall be in the custody of the Trustee. Such Special Funds are pledged in the Indenture as security for the payment of the 1985 Bonds and any Additional Bonds. (See "The 1985 Bonds—Security" at page 7 herein.) For a description of the Special Funds, see "The Indenture—Special Funds" at page 35 herein, "The Indenture—Allocation of 1985 Bond Proceeds" at page 35 herein and "The Lease—Basic Rent and Additional Payments" at page 27 herein.

Sources of Payment of 1985 Bonds: The 1985 Bonds are special obligations of the City and do not constitute a general obligation, debt or bonded indebtedness of the City, the State of Ohio or of any other political subdivision or agency of the State of Ohio, and are payable solely from payments made by the Hospital and other amounts payable under the Lease, Indenture and Guaranty. (See "The 1985 Bonds—Security" at page 7 herein.)

The Study: Attached hereto as Appendix II and made a part hereof is the Comprehensive Economic and Financial Feasibility Study for the Proposed Refunding Program, prepared by Ernst & Whinney and dated January, 1985 (the "Study").

The purpose of the Study is to estimate the Hospital's ability to meet its operating expenses, working capital needs and other financial requirements, including debt service requirements of the 1985 Bonds, during the three-year period ending December 31, 1987.

The Study's forecasts indicate that sufficient funds could be generated to meet the operating expenses, work-

ing capital needs and other financial requirements of the Hospital, including debt service requirements of the 1985 Bonds, during the forecast period, extending through December 31, 1987.

The forecasts are based on assumptions which have been provided by, or reviewed with and approved by, the Hospital's management. However, assumptions may be affected favorably or unfavorably by many factors and, accordingly, there is no assurance the forecasts will be achieved.

The Study must be read in its entirety to understand the assumptions upon which the forecasts are based and the qualifications that have been made, which indicate that there is no assurance the forecasts will be achieved. (See "Appendix II" hereto.)

Debt Service Coverage: Using the Study's forecasts of excess of revenues over expenses before provision for depreciation and interest expense for the years ending December 31, 1986 and December 31, 1987, the estimated annual debt service during those years on the 1985 Bonds (using the Study's assumed principal amount of \$15,075,000 and average annual interest rate on the 1985 Bonds of 11%) is covered 1.85 times and 1.89 times, respectively. (See "Certain Financial Information—Forecasted Debt Service Coverage" at page 26 herein).

**OFFICIAL STATEMENT
RELATING TO THE ORIGINAL ISSUANCE OF**

**\$15,375,000
CITY OF CAMBRIDGE, OHIO**

**HOSPITAL IMPROVEMENT REVENUE REFUNDING BONDS,
SERIES 1985
(GUERNSEY MEMORIAL HOSPITAL PROJECT)**

INTRODUCTION

The City of Cambridge, Ohio (the "Issuer" or "City") is a municipal corporation and a political subdivision organized and existing under the laws of the State of Ohio.

In 1972 the City issued \$7,600,000 principal amount of its Hospital Improvement First Mortgage Revenue Bonds dated January 1, 1972 (the "1972 Bonds") for the purpose of improving and enlarging the then existing hospital facilities of Guernsey Memorial Hospital (the "Hospital"). The 1972 Bonds were issued under and secured by an Indenture of Mortgage dated as of January 1, 1972 (the "1972 Indenture") between the City and The Ohio National Bank of Columbus (now, BancOhio National Bank), as trustee (the "Trustee") and are now outstanding in the aggregate principal amount of \$5,210,000. In 1982 the City issued \$10,410,000 principal amount of its Hospital Improvement Mortgage Revenue Bonds, Series 1982 (Guernsey Memorial Hospital Project) dated October 1, 1982 (the "1982 Bonds") for the purpose of (1) constructing a new addition for surgery and radiology, (2) completing certain shelled space for laboratory, medical records, housekeeping and certain other uses, (3) replacing two existing elevators and adding a third, installing a new roof and adding certain heating, ventilating and air conditioning improvements, and (4) certain additional remodeling. The 1982 Bonds were issued under the 1972 Inden-

ture, as amended by a Supplemental Indenture of Mortgage dated as of October 1, 1982 (the "1982 Indenture", and with the 1972 Indenture herein together called the "Original Indenture") and are now outstanding in the aggregate principal amount of \$10,410,000.

The City now proposes to issue \$15,375,000 principal amount of its Hospital Improvement Revenue Refunding Bonds, Series 1985 (Guernsey Memorial Hospital Project) (herein sometimes called the "1985 Bonds") dated, to mature and to bear interest at the rates per annum as set forth on the front page of this Official Statement and as more fully set forth hereinafter. The 1985 Bonds are to be issued in accordance with the laws of the State of Ohio, particularly Chapter 140, Ohio Revised Code, an ordinance of the City Council of the City (the "Bond Legislation"), and a Trust Indenture dated as of February 1, 1985 (the "Indenture") between the City and the Trustee.

PURPOSE OF BOND ISSUE

Proceeds from the sale of the 1985 Bonds, together with the Equity Contribution of the Hospital, will be used by the City to advance refund the City's outstanding 1972 Bonds and 1982 Bonds, to fund the Debt Service Reserve Fund for the 1985 Bonds and to pay certain costs related to the issuance of the 1985 Bonds (See "Estimated Sources and Uses of Funds").

ADVANCE REFUNDING

1972 Bonds and 1982 Bonds

Pursuant to the terms of an Escrow Agreement dated as of February 1, 1985 (the "Escrow Agreement") among the City, the Hospital and the Trustee, as escrow and refunding trustee (the "Escrow Trustee"), a portion of the 1985 Bonds proceeds, together with a portion of the Hospital

Equity Contribution, will be deposited in a separate trust account with the Escrow trustee and used to purchase (i) from the Department of Treasury, United States Treasury Obligations — State and Local Government Series, and (ii) in the open market, other United States Treasury obligations (collectively called "Government Securities"). Government Securities are direct obligations of the United States of America. The Government Securities will be purchased in such amounts and maturities and will earn interest at such rates as to provide sufficient monies to pay, by redemption or at maturity, all of the principal of, premium for early redemption and interest on the 1972 Bonds and 1982 Bonds.

Upon purchasing the Government Securities in accordance with the terms of the Escrow Agreement and receipt of the verification hereinafter set forth, the 1972 Bonds and the 1982 Bonds will be deemed to have been paid and discharged within the meaning of the Original Indenture and the Original Indenture will cease, determine and become null and void and the City's obligations under such Original Indenture will be discharged and satisfied.

Verification By Independent Accountants

The arithmetical accuracy of the mathematical computations supporting the adequacy of the maturing principal amounts of, and interest earned on, the Government Securities purchased pursuant to the Escrow Agreement to pay the principal of, premium for early redemption and interest on the 1972 Bonds and 1982 Bonds will be verified by Ernst & Whinney prior to the delivery of the 1985 Bonds.

ESTIMATED SOURCES AND USES OF FUNDS

The proceeds of the 1985 Bonds, together with the Equity Contribution of the Hospital, will be applied by the Trustee, under the provisions of the Indenture, for the

following uses and in the following respective estimated amounts (exclusive of accrued interest to be paid on the 1985 Bonds).

Sources of Funds:

1985 Bond Proceeds	\$15,375,000
Hospital Equity Contribution(1)	3,325,000
Total Sources of Funds	\$18,700,000

Uses of Funds:

Deposits to:		
Escrow Fund(2)	\$16,011,200	
Debt Service Reserve Fund(3)	1,929,512	\$17,940,712
1985 Bond discount, legal, consulting, escrow verification and incidental costs(4)		759,288
Total Uses of Funds		\$18,700,000

- (1) The Hospital Equity Contribution includes funds held by the trustee under the Original Indenture, as follows: Debt Service Fund of approximately \$325,000, Debt Service Reserve Fund of approximately \$1,957,000, Replacement and Improvement Fund of approximately \$355,000, and the Contingency Reserve Fund of approximately \$539,000. All such amounts were funded with payments made by the Hospital and not from the proceeds of the 1972 Bonds or 1982 Bonds.
- (2) Represents the amount which will be deposited with the Escrow Trustee and used to purchase Government Securities.
- (3) Represents the amount which is required to be deposited at Bond closing in such Fund by the Hospital and from Hospital funds so that the balance therein equals the maximum principal and interest requirements on the 1985 Bonds in any subsequent fiscal year (the "Debt Service Reserve Requirement").
- (4) Except for 1985 Bond discount, all such expenses are expected to be paid from 1985 Bond proceeds deposited in the Administrative Expense Fund.

THE 1985 BONDS

General Terms

The 1985 Bonds, which shall be dated, bear interest at the rate per annum, and mature in the year and in the principal amounts as shown on the front page hereof, are being issued as serial and term bonds, in registered form only, and in the denominations of \$5,000 and whole multiples thereof.

Interest on the 1985 Bonds will be payable semiannually on June 1 and December 1, commencing June 1, 1985. Principal of and redemption premium, if any, on all 1985 Bonds are payable upon their presentation and surrender at the corporate trust office of the Trustee. Interest on the 1985 Bonds will be mailed to the registered holder as of the applicable record date at the address appearing on the registration books maintained by the bond registrar (currently the Trustee).

1985 Bonds are transferrable and exchangeable without charge to the bondholder upon presentation to the bond registrar and as provided in the Indenture. The Trustee may charge a bondholder an amount equal to any tax or excise required to be paid in connection with any such transfer or exchange.

Security

The 1985 Bonds, including the interest thereon and any redemption premium therefor, are special obligations of the City and are payable solely from the rentals, revenues and other amounts to be received by the City from its ownership of the Leased Premises, or as to be otherwise derived or available, all as provided in the Lease, the Indenture and the Guaranty.

To secure the payment of the principal of, premium, if any, and interest on the 1985 Bonds and any Additional Bonds issued under the Indenture, (1) the City, in the

Indenture, has (i) granted to the Trustee a lien on and a security interest in Hospital Receipts (defined generally as all monies, investments and proceeds of investments received by the City or the Trustee from or in connection with the ownership, lease, operation, acquisition, construction, improvement, equipping or financing of the Leased Premises, including monies in the Special Funds, less any reasonable and proper expenses of the City or the state of operating, maintaining and repairing the Leased Premises), and (ii) assigns to the Trustee (subject to limited exceptions) its right, title and interest in and to the Lease, including the City's right to receive Basic Rent from the Hospital under the Lease, and (2) the Hospital, in the Guaranty, has unconditionally guaranteed to the Trustee the payment of the principal of, premium, if any, and interest on the 1985 Bonds when due.

To secure its obligation to pay Basic Rent and to comply with its other obligations under the Lease, the Hospital, in the Lease, has granted the City a security interest in its Gross Revenues, which security interest has been assigned by the City to the Trustee in the Indenture. (See "The Lease—Pledge of Gross Revenues" for a general description of Gross Revenues.)

To the extent that a security interest can be perfected (i.e., be successfully asserted against a trustee in bankruptcy of the Hospital) in the Gross Revenues by the filing of financing statements, such action will be taken. As to certain items included in Gross Revenues, namely, documents, instruments and cash, perfection can only be accomplished if the City (or the Trustee) also has possession thereof. The Lease does not require that documents, instruments and cash be maintained in the possession of the City (or the Trustee). The City's security interest in the Hospital's Gross Revenues may be subject to limitations on enforceability and may be subordinated by operation of law to the interests and claims of others in several

instances. Under current law, enforceability and priority of those interests may be modified and limited by (i) statutory liens, (ii) rights arising in favor of the United States of America or any agency thereof, (iii) present or future prohibitions against assignment in any federal statutes or regulations, (iv) constructive trusts, equitable liens or other rights impressed or conferred by any state or federal court in the exercise of its equitable jurisdiction, (v) federal bankruptcy laws and state laws governing fraudulent conveyances or affecting assignment of revenues or assets by the Hospital or the City that may affect the enforceability of the Lease or assignments of revenues earned by the Hospital after any effectual institution of proceedings thereunder by or against the Hospital or the City, (vi) rights of third parties in Gross Revenues converted to cash and not in possession of the secured party and (vii) claims which might arise if appropriate financing or continuation statements are not filed in accordance with the Ohio Uniform Commercial Code as from time to time in effect.

The 1985 Bonds, including the interest thereon and any redemption premium therefor, are not general obligations, debt or bonded indebtedness or a pledge of the faith and credit of the City, nor do the 1985 Bonds require the use of the general resources of the City, the State of Ohio or of any other political subdivision thereof, and the holders or owners of such 1985 Bonds shall have no right to have excises or taxes levied by the City, the State of Ohio, or the taxing authority of any political subdivision for the payment thereof.

[INTERMEDIARY'S EXHIBIT F]

**GUERNSEY MEMORIAL HOSPITAL
ACTUAL SOURCE AND USE OF 1985 BOND FUNDS**

Source of Funds	
1985 Bond Proceeds	\$15,375,000
Hospital Equity Contribution	
Debt Service Fund	327,454
Debt Service Reserve Fund	1,967,908
Replacement Fund	354,730
Contingency Fund	539,012
Construction Fund	1,359,725
	<u>4,548,829</u>
Total Sources of Funds	\$19,923,829
Use of Funds	
Deposit to Escrow Fund	\$16,011,200
Deposit to Debt Service Reserve	1,929,512
Bond Financing	786,788
Deposit to Fund Depreciation	1,196,329
Total Uses of Funds	\$19,923,829

[INTERMEDIARY'S EXHIBIT G]

**GUERNSEY MEMORIAL HOSPITAL
CALCULATION OF LOSS ON RE-FINANCING**

New Debt		
Purchase of Escrow Securities		<u>\$16,011,200</u>
Net Reacquisition Price		16,011,200
Old Debt		
1982 Bonds Outstanding	10,410,000	
1972 Bond Outstanding	5,220,000	
Unamortized Bond Financing Costs ..	- 709,499	
Interest expense payable	416,880	
Other	<u>- 1,238</u>	
Net Carrying Amount		<u>15,336,143</u>
Loss on Re-financing		(\$675,057)

Supreme Court of the United States

No. 93-1251

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN
SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ORDER

ORDER GRANTING CERTIORARI. Filed April 4,
1994.

The petition herein for a writ of certiorari to the United
States Court of Appeals for the Sixth Circuit is granted.

April 4, 1994

5
No. 93-1251

Supreme Court, U.S.

FILED

MAY 19 1994

OFFICE OF THE CLERK

In the Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONER

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QUESTIONS PRESENTED

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

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TABLE OF AUTHORITIES

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<i>Batterton v. Francis</i> , 432 U.S. 416 (1977)	38
<i>Batterton v. Marshall</i> , 648 F.2d 694 (D.C. Cir. 1980) ...	38
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<i>Bowles v. Seminole Rock & Sand Co.</i> , 325 U.S. 410 (1945)	29
<i>Butler County Memorial Hosp. v. Heckler</i> , 780 F.2d 352 (3d Cir. 1985)	29
<i>Cheshire Hosp. v. New Hampshire-Vermont Hosp. Serv., Inc.</i> , 689 F.2d 1112 (1st Cir. 1982)	29

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<i>Ford Motor Credit Co. v. Milhollin</i> , 444 U.S. 555 (1980)	30
<i>Friedrich v. Secretary of HHS</i> , 894 F.2d 829 (6th Cir.), cert. denied, 498 U.S. 817 (1990)	38
<i>Gardebring v. Jenkins</i> , 485 U.S. 415 (1988)	29
<i>General Motors Corp. v. Ruckelshaus</i> , 742 F.2d 1561 (D.C. Cir. 1984), cert. denied, 471 U.S. 1074 (1985)	38
<i>Gibson Wine Co. v. Snyder</i> , 194 F.2d 329 (D.C. Cir. 1952)	38
<i>Good Samaritan Hosp. v. Shalala</i> , 113 S. Ct. 2151 (1993)	19, 31
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<i>Martin v. OSHRC</i> , 499 U.S. 144 (1991)	16, 29
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<i>Northern Indiana Public Servs. Co. v. Porter County Chapter of the Izaak Walton League of America, Inc.</i> , 423 U.S. 12 (1975)	29
<i>Pauley v. Beth Energy Mines, Inc.</i> , 111 S. Ct. 2524 (1991)	29
<i>Power Tool Co. v. Commissioner</i> , 439 U.S. 522 (1979)	
<i>Research Medical Center v. Schweiker</i> , 684 F.2d 599 (8th Cir. 1982)	33
<i>Robertson v. Methow Valley Citizens Council</i> , 490 U.S. 332 (1989)	29
<i>Rust v. Sullivan</i> , 500 U.S. 173 (1991)	35
<i>Schweiker v. Gray Panthers</i> , 453 U.S. 34 (1981)	19

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<i>Stinson v. United States</i> , 113 S. Ct. 1913 (1993)	16, 29
<i>Sullivan v. Everhart</i> , 494 U.S. 83 (1990)	35
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<i>Udall v. Tallman</i> , 380 U.S. 1 (1965)	29
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Statutes and regulations:	
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42 U.S.C. 1395c (1988 & Supp. IV 1992)	4
42 U.S.C. 1395d (1988 & Supp. IV 1992)	4
42 U.S.C. 1395g (1988 & Supp. IV 1992)	5
42 U.S.C. 1395h (1988 & Supp. IV 1992)	5
42 U.S.C. 1395i (1988 & Supp. IV 1992)	5
42 U.S.C. 1395x(u) (1988 & Supp. IV 1992)	5
42 U.S.C. 1395x(v)(1)(A)	2, 3, 5, 6, 13, 18, 19, 20, 23
42 U.S.C. 1395x(v)(1)(A)(i)	6, 23, 32, 39
42 U.S.C. 1395cc (1988 & Supp. IV 1992)	5
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5 U.S.C. 553(b)	38
5 U.S.C. 553(b)(A)	38
5 U.S.C. 553(c)	38
5 U.S.C. 706(2)(A)	14, 17, 18, 35, 37
20 C.F.R. Pt. 405 (1967)	6
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42 C.F.R. Pt. 405 (1977)	6
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42 C.F.R. Pt. 412	5
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Miscellaneous:

<i>Accounting and Financial Reporting for Refunding of Debt Reported by Proprietary Activities, Statement of Government Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993)</i>	24
A. Afterman & R. Jones, <i>Governmental Accounting and Auditing Disclosure Manual</i> (1992)	24
American Hospital Ass'n: <i>Cost Finding for Hospitals</i> (1957)	21
<i>Principles of Payment for Hospital Care</i> (Rev. Aug. 1963)	21
<i>Uniform Chart of Accounts and Definitions for Hospitals</i> (1959)	21
APB Statement No. 4 (1970)	22
D. R. Carmichael, S. Lilien & M. Mellman, <i>Accountants' Handbook</i> (7th ed. 1991)	9, 24
I. K. Davis, R. Pierce, Jr., <i>Administrative Treatise</i> (3d ed. 1994)	37
M. Dittenhofer, <i>Applying Government Accounting Principles</i> (1990)	23, 24
<i>Early Extinguishment of Debt, Accounting Principles Board Opinion No. 26</i> (1972)	8-9, 19, 23, 24, 33
31 Fed. Reg. (1966): p. 7864	20-21
p. 14,808	19
p. 14,810	19
p. 14,818	19
41 Fed. Reg. 46,292 (1976)	30
42 Fed. Reg. 52,826 (1977)	6
51 Fed. Reg. 34,790 (1986)	6
Financial Accounting Standards Board, <i>Statement of Concepts No. 6</i> (December 1985)	23-24

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<i>1st Annual Report on Medicare</i> , H.R. Doc. No. 331, 90th Cong., 2d Sess. (1968)	21
R. Kay & D. Searfoss, <i>Handbook of Accounting and Auditing</i> (2d ed. 1989)	24
D. Keller, J. Bulloch & R. Shultis, <i>Management Accountants' Handbook</i> (4th ed. 1992)	23
<i>Medical Care for the Aged: Executive Hearings Before the House Comm. on Ways and Means</i> , 89th Cong., 1st Sess. 142 (1965)	20
<i>Medicare & Medicaid Guide</i> (CCH) (1993):	
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<i>Provider Reimbursement Manual</i> :	
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<i>Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance</i> , 89th Cong., 2d Sess. (1966)	21, 29, 32
<i>Uniform Chart of Accounts and Definitions for Hospitals</i> (1959)	21

In the Supreme Court of the United States

OCTOBER TERM, 1993

No. 93-1251

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF FOR THE PETITIONER

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-14a) is reported at 996 F.2d 830. The opinion of the district court (Pet. App. 15a-37a) is reported at 796 F. Supp. 283. The decision of the Administrator of the Health Care Financing Administration (Pet. App. 40a-53a) and the decision of the Provider Reimbursement Review Board (Pet. App. 54a-84a) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on June 18, 1993. A petition for rehearing was denied on October 4, 1993. Pet. App. 38a-39a. On December 28, 1993, Justice Stevens extended the time for filing a

petition for a writ of certiorari to and including February 1, 1994. The petition for a writ of certiorari was filed on February 1, 1994, and was granted on April 4, 1994. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

1. Section 1861(v)(1)(A) of the Social Security Act, 42 U.S.C. 1395x(v)(1)(A), provides in pertinent part as follows:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services * * *. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific

items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. * * *

2. The regulations of the Secretary of Health and Human Services implementing 42 U.S.C. 1395x(v)(1)(A), 42 C.F.R. Pt. 413, provide in pertinent part as follows:

§ 413.9 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. * * *

§ 413.20 Financial data and reports.

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts,

as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

* * * * *

§ 413.24 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting.

* * * * *

(b) Definitions —

* * * * *

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

3. Section 233 of the Secretary's Provider Reimbursement Manual is reprinted at Pet. App. 85a-89a.

STATEMENT

1. Medicare is a national program of health insurance for the aged and disabled. Part A of Medicare provides for the payment of inpatient hospital and related post-institutional care for the eligible individuals who are the program's "beneficiaries." 42 U.S.C. 1395c, 1395d and

1395i (1988 & Supp. IV 1992). Services are furnished under Part A by "providers of services" (e.g., hospitals), which participate by entering into a "provider agreement" with the Secretary. 42 U.S.C. 1395x(u) and 1395cc (1988 & Supp. IV 1992). The Secretary reimburses Medicare providers on an annual basis through "fiscal intermediaries." 42 U.S.C. 1395g and 1395h (1988 & Supp. IV 1992). The fiscal intermediary in this case is Community Mutual Insurance Company (Blue Cross/Blue Shield). Admin. Rec. 1032.

Respondent Guernsey Memorial Hospital is a Medicare provider. For the 1985 cost year at issue in this case, providers like respondent were reimbursed for capital-related costs on a "reasonable cost" basis.¹ The Medicare Act defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services" to beneficiaries. 42 U.S.C. 1395x(v)(1)(A). The Act authorizes the Secretary to promulgate regulations "establishing the method or methods to be used" for determining such costs. *Ibid.* The Act also directs the Secretary, in prescribing such regulations, to "consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of pay-

¹ Since October 1, 1983, most hospitals have been reimbursed for general inpatient operating costs under a system of predetermined rates known as the "prospective payment system" or "PPS." See 42 U.S.C. 1395ww(d) (1988 & Supp. IV 1992); 42 C.F.R. Pt. 412. Reimbursement for capital-related costs (like those involved in this case) continued to be made on a "reasonable cost" basis until the beginning of a transition to a "capital PPS" on October 1, 1991. The transition is scheduled to be completed by October 1, 2001. See 42 C.F.R. 412.304.

ment to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers." *Ibid.* Finally, the Act requires that provider reimbursement be specifically related to beneficiary care by mandating that only costs "necessary in the efficient delivery of needed health services" be reimbursed and that the "necessary costs of efficiently delivering covered services to [Medicare beneficiaries] * * * not be borne by individuals not so covered, and the costs with respect to individuals not so covered * * * not be borne by [the Medicare program]." 42 U.S.C. 1395x(v)(1)(A) and (i). (The latter requirement is known as the prohibition against "cross-subsidization.") The regulations that set forth general principles of reasonable cost reimbursement for Medicare purposes are codified at 42 C.F.R. Pt. 413.²

2. In 1972 and 1982, the City of Cambridge, Ohio, issued bonds on respondent's behalf to raise money for various capital improvements to respondent's facilities.³ Pet. App. 3a. The bonds were secured by mortgages on hospital property, bore interest at rates ranging from 5.25% to 12.5%, and were scheduled to mature in full by 1996 in the case of the 1972 bonds and by 2012 in the case

² The Medicare "reasonable cost" regulations were originally codified at 20 C.F.R. Pt. 405 (1967). They have been twice redesignated, first at 42 C.F.R. Pt. 405 (1977), see 42 Fed. Reg. 52,826 (1977), and most recently at 42 C.F.R. Pt. 413, see 51 Fed. Reg. 34,790 (1986). Neither redesignation affected the substance of the regulations at issue in this case. In this brief, we refer to the regulations as currently codified, giving parallel citations only where useful.

³ The 1985 refunding bonds discussed below were also issued by the City of Cambridge. See Pet. App. 56a; Admin. Rec. 440-535 (1985 trust indenture); J.A. 54, 55, 84 (bond prospectuses).

of the 1982 bonds. See *id.* at 3a, 55a-56a; J.A. 54. Outstanding bonds from the 1972 and 1982 series could also, at respondent's option, be repaid ("called") beginning in 1984 and 1992, respectively, in exchange for the payment of a "call premium" (prepayment penalty) in addition to the basic principal amount. See Pet. App. 56a; J.A. 54, 55.

The interest payments on the 1972 and 1982 bonds, as well as the costs associated with their issuance (such as underwriter's discounts and legal and accounting fees), were allowable capital-related costs for purposes of Medicare reimbursement. See, e.g., 42 C.F.R. 413.9(b)(2); 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153. Interest costs on the bonds were incurred and reimbursed annually by Medicare each year that the bonds remained outstanding. Respondent's bond issuance costs, by contrast, were fully incurred in 1972 and 1982 (when the bonds were issued) but were not reimbursable in full in the year incurred. Instead, both for financial accounting and Medicare reimbursement purposes, the bond issuance costs were amortized as part of respondent's costs over the life of the bonds. See Pet. App. 3a-4a.

3. In 1985, the City of Cambridge issued new bonds on respondent's behalf to refinance the 1972 and 1982 bonds in an "advance refunding" or "defeasance" transaction. In that transaction, the bulk of the proceeds of the new bonds, together with certain other funds, were transferred to an irrevocable escrow account established under the control of a trustee for the purpose of paying interest on the old bonds while they remained outstanding and retiring them at the earliest possible "call" date. See Pet. App. 3a, 16a-17a.⁴ Under the terms of the old

⁴ Respondent anticipated receipt of \$15,375,000 in proceeds from the 1985 bonds. To that amount, respondent proposed to add an "equity" contribution of \$3,325,000, principally derived from

bonds, the establishment and funding of the escrow account released respondent from any further obligation to the holders of those bonds. The refinancing also eliminated certain restrictions imposed on respondent under the old bonds and freed up funds required by those bond issues for other capital purposes, including the purchase of new equipment and improvements to its facility. Admin. Rec. 191-192. Respondent estimated that the refinancing would save it approximately \$12 million in debt service costs over the remaining original terms of the 1972 and 1982 bond issues. Pet. App. 3a, 16a, 56a; Admin. Rec. 189; J.A. 17, 76.

Because the amount that respondent was required to pay into the refunding escrow account in order to defease its obligations under the 1972 and 1982 bonds exceeded the net amount at which those bonds were carried on respondent's books, respondent realized, at the time of the transaction, an accounting "loss" equal to that difference.⁵ Pet. App. 44a, 56a-57a. The parties stipulated that the amount of the accounting loss was \$672,581. J.A. 26.

various debt service and contingency funds required under the terms of the 1972 and 1982 bonds, as follows: \$325,000 from the Debt Service Fund, \$1,957,000 from the Debt Service Reserve Fund, \$355,000 from the Replacement and Improvement Fund and \$539,000 from the Contingency Reserve Fund. From these total proceeds of \$18,700,000, respondent planned to pay \$16,011,200 into the escrow fund managed by the Trustee, \$1,929,512 into a Debt Service Reserve Fund and \$759,288 in bond discount, legal, consulting and incidental costs for the 1985 bond issuance. J.A. 93. See also J.A.97; Admin. Rec. 211-213.

⁵ For these purposes, the net carrying amount of the refunded debt consisted of the combined outstanding principal amounts of the 1972 and 1982 bonds, increased by accrued but unpaid interest, and offset by the original bond issuance costs that remained unamortized at the time of the refunding transaction. Pet. App. 57a; Admin. Rec. 196-199, 877; see J.A. 63; *Early Extinguishment*

4. a. For financial reporting purposes, respondent reflected the full amount of the refunding loss in 1985 (the year of the transaction) in accordance with "generally accepted accounting principles" (GAAP), as set out in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (1972) (APB Opinion 26).⁶ See Pet. App. 4a; J.A. 63. Respondent also included the entire amount of the refunding loss in its Medicare cost report for that year. The "fiscal intermediary" responsible for review of respondent's cost report did not question the calculation of the refunding loss, but determined that the loss could not all be claimed in the year of the transaction. Admin. Rec. 347-357, 1038-1039. The intermediary's determination relied on a guideline

of *Debt*, Accounting Principles Board Opinion No. 26, ¶ 3(b) (1972). The difference between that amount and the amount that respondent paid into escrow—that is, the accounting loss recognized on the transaction—reflected not only the unamortized issuance costs, but also a call premium on the 1982 bonds (payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account) and the difference between the interest rates payable on the refunded bonds and rates prevailing at the time of the refunding transaction (which affected the amount necessary to fund the escrow account). See Pet. App. 44a.

⁶ GAAP consists of principles established by certain "standards setting organizations" and "professional societies. Two of the "standards setting organizations" are the Financial Accounting Standards Board (FASB) and the Government Accounting Standards Board (GASB); the professional societies include the American Institute of Certified Public Accountants (AICPA). See D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 2.4(a), 2.5, 2.9 (7th ed. 1991). In the absence of an applicable formal standard from one of those organizations, what is "generally accepted" depends on "the consensus of the accounting profession" as manifested in treatises and other publications. See *ibid.*; Pet. App. 4a n.1.

contained in Section 233 of the Secretary's Provider Reimbursement Manual (PRM), an extensive set of detailed policies and guidelines issued to assist providers and intermediaries in applying the principles of reimbursement set forth in the Medicare regulations. See 1, 2 *Medicare & Medicaid Guide* (CCH) ¶¶ 4600-8113 (1993); App., *infra*, 1a.

Section 233 of the PRM, issued in 1983 and reprinted at Pet. App. 85a-89a, applies to "advance refunding" transactions like that undertaken by respondent in 1985. Section 233 identifies the individual expense elements of an "advance refunding" transaction and specifies when such expenses are allowable for Medicare reimbursement purposes. It provides, for example, that while incidental expenses (such as legal fees) relating to the refunding transaction are allowable as soon as paid or accrued, "call premiums" on the refunded debt are not allowable until the period in which they are in fact paid to holders of the refunded debt, and unamortized issuance costs of the refunded debt must be amortized over the period from the issuance of the refunding debt to the date that the refunded debt is actually repaid. PRM § 233.3(B)(1), (B)(3) and (C); Pet. App. 86a-87a. The overall approach of Section 233 is "to implicitly recognize any gain or loss incurred as the result of an advance refunding over [the period that the principal of the old debt remains unpaid], rather than immediately." PRM § 233.3; Pet. App. 87a.

b. Respondent appealed to the Provider Reimbursement Review Board (PRRB) (see 42 U.S.C. 1395oo(a); 42 C.F.R. 405.1835-405.1873), which reversed the fiscal intermediary's determination. Pet. App. 54a-84a. Without directly addressing the validity of PRM § 233, the PRRB held that Sections 413.20 and 413.24 of the Medicare regulations (42 C.F.R. 413.20, 413.24) required that the al-

lowance of costs for Medicare reimbursement purposes be determined according to GAAP. Pet. App. 75a-76a, 82a.

c. The Administrator of the Health Care Financing Administration reversed the PRRB's decision.⁷ Pet. App. 40a-53a. The Administrator explained (*id.* at 45a-47a; footnotes omitted):

While GAAP can be useful in determining costs related to patient care, they are not necessarily controlling. § 1861(v)(1)(A) of the Act only required the Secretary to "consider. . . the principles generally applied by national organizations;" the Secretary is not required to adopt them for determining reimbursable cost. Neither Congress nor the Secretary abdicated to the accounting profession the responsibility for determining Medicare reimbursement policy.

When evaluating whether it is appropriate to use GAAP for calculating Medicare reimbursement, one must first consider whether Medicare has a specific policy in effect. If Medicare does not, one must determine whether GAAP will identify costs that are in economic reality borne by the provider, and if so, whether the cost is properly related in time to care being rendered to Medicare beneficiaries.

The Administrator finds that for the Provider's fiscal year under review, Medicare did have a specific policy in effect governing the treatment of refunding transactions. That policy, found in § 233 of the

⁷ The decision of the Administrator is the final agency action and constitutes the decision of the Secretary. See 42 U.S.C. 1395oo(f)(1); 42 C.F.R. 405.1875.

Provider Reimbursement Manual * * * was effective for [the refinancing at issue here.]

The effect of § 233 is to require the loss on a refunding to be amortized over a number of years. This section is interpretive of 42 CFR 405.451, "Cost Related to Patient Care" [now 42 C.F.R. 413.9] which requires payments to be based on "the actual cost of services rendered to beneficiaries during the year." This policy more accurately reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries than does APB No. 26.

The Administrator noted (Pet. App. 47a-49a):

The economic realities of the case at hand demonstrate the superiority of amortizing the loss on defeasance, rather than allowing the full cost in the year of refinancing. While the Provider's obligation on the original bond issue to repay principal of approximately \$15.6 million increased slightly with the refinancing, the overall interest obligation over the remaining term of the borrowing would decrease substantially.

* * * * *

* * * The loss was merely an adjustment to the Provider's capital structure which enabled the Provider to substitute less expensive financing for its existing more expensive financing. Thus, the loss on the refinancing did not relate exclusively to patient care services rendered in the year of the loss. The loss is more closely related to the years over which the original bond term extended (the period

over which the lower interest will be enjoyed) than to the year in which the refunding occurred.

The Administrator concluded that the policy of PRM § 233 should apply to respondent's 1985 transaction in order "to amortize the loss on the advance refunding over those periods which benefit from the reduced interest rate." Pet. App. 51a.

5. a. The district court upheld the Administrator's determination. Pet. App. 15a-37a. The court concluded that neither the Act nor the Secretary's regulations require strict adherence to GAAP for Medicare reimbursement purposes. *Id.* at 31a-32a. The court concluded that it was not arbitrary or capricious for the Secretary to depart from GAAP in this case because "the Secretary has a rational basis for concluding that, by amortizing this particular cost, he has more closely approximated the impact of the [refunding] transaction upon the provider's cost of patient care." *Id.* at 33a.

b. The court of appeals reversed. Pet. App. 1a-14a. The court acknowledged that the Medicare Act does not itself require the use of GAAP for reimbursement purposes. Instead, the Act directs the Secretary to prescribe "regulations establishing the method or methods to be used" (*id.* at 6a, quoting 42 U.S.C. 1395x(v)(1)(A)). The court noted (Pet. App. 7a), however, that the Secretary's regulations specify that "[s]tandardized * * * accounting * * * and reporting practices * * * are followed" for Medicare purposes (42 C.F.R. 413.20), that "[c]hanges in these practices and systems will *not* be required in order to determine" allowable costs (*ibid.*), and that "cost data *must* be based on * * * the accrual basis of accounting." 42 C.F.R. 413.24(a). The court interpreted these general directives to represent "a flat statement that generally accepted

accounting principles" are to be followed in Medicare reimbursement determinations. Pet. App. 6a.

The court recognized that there was "nothing irrational" about the non-GAAP treatment of advance refunding costs provided under Section 233 of the PRM, and it had "no[] doubt" that the Secretary had authority under the Medicare Act to adopt that policy. Pet. App. 8a-9a. Because the court interpreted the Secretary's general regulations to require adherence to GAAP, however, the court concluded that to follow Section 233 of the PRM would "work[] a substantive change in existing regulations" and "impermissibly change[]" their meaning. Pet. App. 9a, 10a. The court therefore viewed Section 233 as a "legislative" rather than an "interpretative" rule (Pet. App. 9a) and held that it was "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." *Id.* at 3a. The court accordingly remanded the case for entry of summary judgment against the Secretary on the advance refunding issue.⁸

SUMMARY OF ARGUMENT

The administrative order at issue in this case requires amortized, rather than immediate, reimbursement of "advance refunding" costs for Medicare providers. That order is valid because it is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2)(A).

⁸ Both the district court (Pet. App. 34a-37a) and the court of appeals (*id.* at 14a) also addressed a separate issue involving the treatment of interest earned by respondent on an account established to accumulate funds for the payment of interest on the 1985 refunding bonds. Both courts ruled in favor of the Secretary on that question, and it is not at issue here.

The courts below properly acknowledged that requiring amortized, rather than immediate, reimbursement is a rational "treatment of advance refunding costs" (Pet. App. 8a) which, in light of statutory Medicare reimbursement policies, "cannot be considered arbitrary or capricious." *Id.* at 32a. The court of appeals held, however, that the Secretary had precluded such rational treatment of these costs by adopting regulations which, in the court's view, contain "a flat statement" that generally accepted accounting principles (GAAP) must be applied in adjudicating Medicare reimbursement claims. *Id.* at 6a.

That understanding of the regulations is not correct. Neither the statute nor the regulations contain such a requirement, much less a "flat statement" to that effect. By directing that claims for reimbursement be submitted under an "accrual accounting" method, the Secretary did not adopt the particular version of "accrual accounting" employed as GAAP for financial accounting purposes. The objectives of Medicare reimbursement and of financial accounting may, and in this context do, vary significantly. There is thus no "presumptive equivalency" (*Thor Power Tool Co. v. Commissioner*, 439 U.S. 522, 543 (1979)) between the two methods.

The agency's longstanding interpretation and application of the regulations confirm that no rigid GAAP requirement exists for Medicare reimbursement. Soon after the first adoption of the reimbursement regulations, the agency issued the Provider Reimbursement Manual, which contains a detailed set of policies and guidelines to assist in Medicare reimbursement determinations. The Manual recognizes that Medicare policies do not always conform to financial accounting objectives, and specifies that GAAP is to be applied only for cost situations "not covered by the

manual's guidelines and policies" (App., *infra*, 1a). The Secretary's reasonable interpretation of the agency's own regulations is entitled to "controlling weight." *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993). See also *Martin v. OSHRC*, 499 U.S. 144, 150-151 (1991).

The guideline set forth in Section 233 of the Manual specifies that amortized, rather than immediate, reimbursement of "advance refunding" costs is proper for Medicare purposes. A central issue in determining the amount of reimbursement due a provider hospital under Medicare is what costs may properly be reimbursed for a particular cost year. In making this annual evaluation, the Secretary must match any costs "allowed" under Medicare to services provided to the program's beneficiaries during that year. In the case of allowable costs that relate to more than one accounting year—such as, in this case, capital costs from which benefits will be derived over several years—proper periodic allocation is necessary if Medicare is to pay only that portion of the overall costs that relates to the varying use of hospital facilities by Medicare patients over the years in question. It is ultimately the responsibility of the Secretary, and not the accounting profession, to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods for Medicare purposes. The Secretary's conclusion that the costs at issue here must be apportioned over several periods is entirely justified, both as a programmatic and as a factual matter, and is neither arbitrary, capricious nor an abuse of discretion. The decision of the court of appeals should therefore be reversed.

The court of appeals' basic error in interpreting the Secretary's regulations gave rise to its equally erroneous conclusion that Section 233 of the PRM "effects a

substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of the agency's failure to comply with the Administrative Procedure Act in adopting it." Pet. App. 3a. That conclusion has no force independent of the court's determination that the Manual provision, which was issued without formal notice and comment, conflicts with a GAAP accounting requirement embodied in the Secretary's regulations. As we have explained above, the regulations contain no such GAAP requirement and Section 233 of the PRM is a rational and valid interpretation of the regulations.

ARGUMENT

I. THE SECRETARY'S MEDICARE REGULATIONS DO NOT MANDATE PROVIDER REIMBURSEMENT ACCORDING TO GAAP, AND THE SECRETARY PROPERLY REQUIRED RESPONDENT'S CAPITAL-RELATED COSTS TO BE AMORTIZED

1. This case concerns the validity of an administrative order requiring amortized, rather than immediate, reimbursement of certain Medicare provider costs. The agency's order must be sustained unless it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. 706(2)(A).⁹

The court of appeals did not conclude that the Secretary's ruling now at issue in this case was arbitrary or capricious or an abuse of discretion. To the contrary, the court acknowledged that requiring amortized, rather than immediate, reimbursement is a

⁹ The provisions of chapter 7 of title 5 of the United States Code are expressly made applicable to actions by providers for judicial review of the Secretary's decision. See 42 U.S.C. 1395oo(f)(1).

rational "treatment of advance refunding costs" that the Secretary reasonably could determine "squares with economic reality." Pet. App. 8a. The district court similarly concluded that "the Secretary has a rational basis for concluding that this particular loss should be amortized over the life of the pre-existing debt" and that the agency's order "cannot be considered arbitrary or capricious." *Id.* at 32a.

The court of appeals held, however, that the Secretary's admittedly rational determination was invalid because, in the court's view, it conflicted with "a flat statement [in the agency's regulations] that generally accepted accounting principles" are to be followed in adjudicating Medicare reimbursement claims. Pet. App. 6a. The court of appeals thus concluded, without stating specifically, that the Secretary's order was "not in accordance with law." 5 U.S.C. 706(2)(A). That conclusion is not correct.

a. The court of appeals acknowledged that the Medicare provisions of the Social Security Act impose no requirement that GAAP be used for all Medicare reimbursement determinations. Pet. App. 6a. Instead, the Act explicitly assigns to the Secretary the authority to "establish[] the method or methods to be used, and the items to be included, in determining [allowable] costs." 42 U.S.C. 1395x(v)(1)(A). It further provides that in establishing those methods the Secretary (*ibid.*):

may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on * * * costs * * *, and may provide for the use of charges or a percentage of

charges where this method reasonably reflects * * * costs.

This Court has noted the "broad authority" conferred upon the Secretary by this language to prescribe standards for reimbursement. *Good Samaritan Hosp. v. Shalala*, 113 S.Ct. 2151, 2161 n.13 (1993), quoting *Heckler v. Campbell*, 461 U.S. 458, 466 (1983), quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981). Given that broad and flexible mandate to the Secretary, it is exceedingly unlikely that the Secretary would have intended, in general regulations promulgated as part of the initial implementation of the Medicare Act,¹⁰ to abdicate to the accounting profession (or to anyone else) ultimate responsibility for making particular cost reimbursement determinations. The court of appeals' conclusion (Pet. App. 6a) that the agency's regulations contain "what appears to be a flat statement" to that effect is thus implausible for that reason alone.

The court of appeals noted that the Act requires the Secretary, in prescribing cost-determination regulations, to "consider * * * principles generally applied by national organizations." Pet. App. 6a, quoting 42 U.S.C. 1395x(v)(1)(A). Relying on that language, the court con-

¹⁰ The language of the relevant regulations dates from the outset of the Medicare program. See 31 Fed. Reg. 14,808, 14,810, 14,818 (1966); 20 C.F.R. 405.406(a), 405.453(a) and (b)(2) (1967). The regulations, which are now codified at 42 C.F.R. 413.20 and 413.24, were promulgated *before* the accounting profession adopted a GAAP standard for accounting for advance refunding transactions in 1972. See APB Opinion No. 26, ¶¶ 4-10; J.A. 64-67. Respondent's thesis therefore must be that, while the Secretary's method of accounting for such transactions was permissible under the regulations at the time they were issued, that method of accounting ceased to be permissible at the moment the Accounting Principles Board promulgated APB Opinion No. 26.

cluded that the Act was intended to direct the Secretary to consider the general *financial accounting* principles of "national organizations," and specifically GAAP (which the court felt that it could "safely assume" such "national organizations" would apply). Pet. App. 6a. In quoting the statute, however, the court omitted a large portion of the relevant statutory text. Section 1395x(v)(1)(A) goes on to state that the Secretary is to "consider * * * principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers." 42 U.S.C. 1395x(v)(1)(A) (emphasis added). Read as a whole, the statutory text plainly directs the Secretary to "consider" the *reimbursement* principles developed by national insurance or prepayment organizations in the health services sector. It neither explicitly nor implicitly directs the Secretary to apply GAAP *accounting* principles developed for financial reporting purposes.

The legislative history of the Act supports this understanding. During hearings on the original Medicare legislation, Social Security Commissioner Ball stated that his agency would generally "expect to follow" the "principles of payment for hospital care" set forth in a 17-page pamphlet produced by the American Hospital Association (AHA). *Medical Care for the Aged: Executive Hearings Before the House Comm. on Ways and Means*, 89th Cong., 1st Sess. 142 (1965). Later, in proposing the first set of Medicare regulations, Commissioner Ball reported that, in conformity with the statutory provision quoted by the court of appeals, he had consulted with representatives of the AHA and similar groups. 31 Fed.

Reg. 7864 (1966); see also *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 45, 59, 61-63, 197-198 (1966); *1st Annual Report on Medicare*, H.R. Doc. No. 331, 90th Cong., 2d Sess. 39-40 (1968). Neither the AHA pamphlet, nor either of the two subsidiary publications on which it relied, referred to GAAP as a guiding principle of hospital reimbursement. See American Hospital Ass'n, *Principles of Payment for Hospital Care* (Rev. Aug. 1963);¹¹ AHA, *Uniform Chart of Accounts and Definitions for Hospitals* (1959); AHA, *Cost Finding for Hospitals* (1957). The available evidence thus confirms what is in any event the natural reading of the statutory language: that the "principles * * * applied by national organizations or established prepayment organizations" that the statute requires the Secretary to "consider" have nothing specifically to do with GAAP.

An understanding of the specific objectives of financial accounting confirms the same conclusion. As this Court

¹¹ The pamphlet stated (at 6) that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting"—a general principle similar to that eventually adopted by the Secretary in what is now 42 C.F.R. 413.20. See also Br. in Opp. 13-14. The pamphlet's explanatory comment went on to state (at 6-7), however, that "[h]ospitals must agree to provide the basic information necessary for comparable analysis of cost and equitable distribution of payments for third-party purchasers. * * * Only through uniformity of records and reports can third-party agencies be assured that they are paying for similar services in different hospitals on comparable bases." (Emphasis added). As with the regulatory language discussed below, those statements were undoubtedly directed toward the "uniformity of records and reports" required of providers, rather than toward whether particular costs are appropriate for reimbursement by the Secretary in particular periods.

has noted, financial accounting is designed "to provide useful information to management, shareholders, creditors, and others properly interested" and "has as its foundation the principle of conservatism." *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522, 542 (1979).¹² The "corollary" of this principle of conservatism for financial accounting is that "possible errors in measurement [should] be in the direction of under-statement rather than overstatement of net income." *Ibid.*, quoting APB Statement No. 4, ¶ 171 (1970). Thus, expenses incurred by a business that might reasonably be amortized may,

¹² In *Thor Power Tool*, the Court considered an analogous question concerning the authority of the Commissioner of Internal Revenue to restate a taxpayer's accounts to "clearly reflect income" (26 U.S.C. 476(b)). The Court rejected the taxpayer's assertion that an accounting principle that conforms to GAAP must be presumed to be permissible for tax purposes (439 U.S. at 542-543; footnote omitted):

[T]he presumption petitioner postulates is insupportable in light of the vastly different objectives that financial and tax accounting have. The primary goal of financial accounting is to provide useful information to management, shareholders, creditors, and others properly interested; the major responsibility of the accountant is to protect these parties from being misled. The primary goal of the income tax system, in contrast, is the equitable collection of revenue; the major responsibility of the Internal Revenue Service is to protect the public fisc. Consistently with its goals and responsibilities, financial accounting has as its foundation the principle of conservatism, with its corollary that "possible errors in measurement [should] be in the direction of understatement rather than overstatement of net income and net assets." In view of the Treasury's markedly different goals and responsibilities, understatement of income is not destined to be its guiding light. Given this diversity, even contrariety, of objectives, any presumptive equivalency between tax and financial accounting would be unacceptable.

under the principle of "conservatism," nonetheless be expensed immediately for purposes of financial accounting. APB Opinion No. 26 itself represents an application of "conservatism" in financial accounting, for it accelerates the recognition of expenses that would otherwise be amortized over the remaining life of the original loan. See APB Opinion No. 26, ¶¶ 5-8; J.A. 64-66.

The purpose of Medicare reimbursement, by contrast, is to provide payment of "the necessary costs of efficiently delivering covered services to [Medicare beneficiaries.]" 42 U.S.C. 1395x(v)(1)(A)(i). That purpose obviously is not identical to the objective of financial accounting. See pages 31-35 and notes 19, 20, *infra*. As a result, no "presumptive equivalency" (*Thor Power Tool Co. v. Commissioner*, 439 U.S. at 543) between Medicare reimbursement and financial accounting was embedded in the provisions of the Medicare Act.

b. The language of the regulations relied upon by the court of appeals (Pet. App. 6a-8a) provides no more support for its holding. The more detailed of those regulations specifies only that providers are to support their claims for Medicare reimbursement with "adequate cost data" based on "an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. 413.24(a). The court of appeals read the requirement that cost data be based "on the accrual basis of accounting"—rather than on cash receipts and disbursements—to entail automatic imposition, in every detail, of the *particular version* of accrual accounting embodied in GAAP. Pet. App. 7a-8a. Accrual accounting, however, is not synonymous with GAAP. See generally D. Keller, J. Bulloch & R. Shultis, *Management Accountants' Handbook* pp. 1.2-1.3 (4th ed. 1992); M. Dittenhofer, *Applying Government Accounting Principles* §§ 9.03-9.04 (1990) (discussing "accrual" and "modified accrual" accounting); Financial

Accounting Standards Board (FASB), Statement of Concepts No. 6, ¶¶ 144-149 (December 1985).¹³ Indeed, in areas where a particular GAAP standard has not been established, or where GAAP recognizes more than one approach, a variety of quite different approaches may be recognized as legitimate methods of accrual-basis accounting. See, e.g., APB Opinion 26, ¶¶ 4-10; J.A. 64-67.

The court's interpretation would be strained even if the regulation itself provided no definition of this term. In fact, however, Section 413.24(b)(2) provides a specific definition of "accrual accounting":

Accrual basis of accounting. Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected,

¹³ It is widely recognized that "[f]inancial accounting and reporting is only part of the broad field of accounting." D. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* 3 (7th ed. 1991). Indeed, accrual accounting for state and local governments and their proprietary activities is governed by the standards of the Governmental Accounting Standards Board (GASB), which differ from the GAAP applicable to private entities relied upon by respondent here—but which in fact constitute "GAAP" for those entities to which they apply. R. Kay & D. Searfoss, *Handbook of Accounting and Auditing*, pp. 31-4 to 31-10 (2d ed. 1989); M. Dittenhofer, *Applying Government Accounting Principles* § 1.03[b][2] (1990); A. Afterman & R. Jones, *Governmental Accounting and Auditing Disclosure Manual* § 1 (1992). The GASB's Statement of Governmental Accounting Standards No. 23 requires covered entities to report gains and losses on advance refunding transactions on a deferred basis very similar to that required by the Secretary for purposes of Medicare reimbursement. See *Accounting and Financial Reporting for Refundings of Debt Reported by Proprietary Activities*, Statement of Government Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993). It should be noted that the bonds involved in this case were issued by the City of Cambridge, Ohio, on respondent's behalf. See Pet. App. 56a.

and expenses are reported in the period in which they are incurred, regardless of when they are paid.

This broad definition nowhere mentions GAAP—an organized and relatively specific set of particular accounting principles and decisions that could (and surely would) have been easily referenced had the drafters of the regulation intended to incorporate them in detail into a general requirement of accrual accounting. In any event, 42 C.F.R. 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary (or a fiscal intermediary acting on her behalf) in determining which costs are allowable under Medicare in any given period. See pages 31-35, *infra*. Section 413.24 clearly provides only the starting point for the Secretary's reimbursement determination. It is not, as respondent claims, the ending point.¹⁴

¹⁴ Respondent argues (Br. in Opp. 17-18) that the "cost finding" language of Section 413.24 demonstrates that the references in that section to accrual accounting apply to the Secretary's reimbursement determinations, rather than simply to the manner by which the provider's records must be maintained. The "cost finding" required by the regulations refers to the process of apportioning general and indirect costs (e.g., administrative costs) to recognized cost centers for purposes of Medicare reimbursement. See generally 42 C.F.R. 413.24(d). That process merely requires the provider to reorganize some of its normal financial data in a way specifically designed to help identify which of its costs for the relevant period are allowable under the special standards of the Medicare program. The requirement that providers "recast" their basic financial data in preparing their Medicare cost reports, moreover, refutes respondent's broad assertion (Br. in Opp. 15) that Section 413.20(a) (discussed below) somehow guarantees that, in order to receive Medicare

The even more general provisions of 42 C.F.R. 413.20(a) provide equally little support for the court's analysis, although their purpose and effect are more ambiguous. Originally placed at the end of a series of essentially prefatory sections of the initial Medicare regulations (see 20 C.F.R. 405.406 (1967)), Section 413.20(a) provides:

The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement. Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basi[c] accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries.

Because of its broad terms and its placement in the original set of regulations, it is unlikely that Section 413.20(a) was ever intended to do more than provide general reassurance to providers contemplating participation in the Medicare program that they would not be required fundamentally to alter their accounting practices for reporting purposes and to alert a reader to the record-keeping and cost accounting requirements set out in more detail in what later became Section

reimbursement, providers need do no more than present the Secretary with their "basic accounts, as usually maintained."

413.24.¹⁵ In any event, Section 413.20(a) by its terms does not require use of GAAP. It refers only to practices that are standard "in the hospital and related fields," suggesting if anything the use of "specially" rather than "generally" accepted principles. And, of particular relevance here, Section 413.20(a) states that the methods for determining allowable costs under Medicare "[e]ssentially * * * involve *making use of data available from the [provider's] basi[c] accounts, as usually maintained, to arrive at*" proper reimbursement (emphasis added). There is no suggestion in this language that those methods—which "essentially" involve the "use" of data from the provider's accounts—entail rigid acceptance of the provider's own cost accounting figures (whether GAAP-based or otherwise) without further adjustment in light of the purposes and requirements of the Medicare program.

As in the case of Section 413.24, then, Section 413.20 is directed toward ensuring the existence of provider records sufficient to enable the Secretary and fiscal intermediaries to calculate the costs allowable under Medicare, not toward prescribing how that calculation will be made. Compare, *e.g.*, 42 C.F.R. 413.53 (specifying detailed rules for apportionment of costs between Medicare and non-Medicare patients); 42 C.F.R. 413.134-413.149 (specifying allowable depreciation costs). Contrary to respondent's view, Section 413.20 (like Section 413.24) provides a starting point, rather than an ending point, for the Secretary's reimbursement determination.

¹⁵ Compare the correspondence between original Sections 405.406 and 405.453 (now 413.20 and 413.24); 405.405 and 405.454 (now 413.60 and 413.64); 405.403-405.404 and 405.452 (now 413.50 and 413.53 (Section 405.404 has no current counterpart)); and 405.402 and 405.451 (now 413.5 and 413.9).

c. This understanding of the text of the regulations is confirmed by the Secretary's longstanding interpretation and by consistent administrative practice. Soon after enactment of the Medicare Act and adoption of implementing regulations, the Secretary issued the Provider Reimbursement Manual to provide "guidelines and policies to implement Medicare regulations" and to "set forth principles for determining the reasonable cost of provider services." App., *infra*, 1a. The Manual recites (*id.* at 2a; (emphasis added)):

The procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally * * *. The manual contains informational and procedural material on various aspects of the determination of cost and to assist providers in preparing annual cost reports. * * * *For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.*

The Secretary's original and longstanding interpretation of the regulations, and the agency's consistent practice under them, has thus been that GAAP is used only as a stop-gap; GAAP is applied only for a "cost situation that is not covered by the manual's guidelines and policies." *Ibid.*) And those "guidelines and policies" are themselves designed to accommodate the specific "program needs" of Medicare's "reasonable cost regulations." *Ibid.*

The Court has consistently held that an administrative interpretation of a regulation by the agency that issued it is entitled to "controlling weight

unless it is plainly erroneous or inconsistent with the regulation." *Udall v. Tallman*, 380 U.S. 1, 16-17 (1965), quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945). See *Stinson v. United States*, 113 S. Ct. 1913, 1919 (1993); *Martin v. OSHRC*, 499 U.S. 144, 150-151 (1991); *Robertson v. Methow Valley Citizens Council*, 490 U.S. 332, 359 (1989); *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988); *Northern Indiana Public Serv. Co. v. Porter County Chapter of the Izaak Walton League of America, Inc.*, 423 U.S. 12, 15 (1975); *Ehlert v. United States*, 402 U.S. 99, 105 (1971). Deference is particularly appropriate when, as here, the question of interpretation arises under "a complex and highly technical regulatory program" entailing "significant expertise, and * * * the exercise of judgment grounded in policy concerns." *Pauley v. BethEnergy Mines, Inc.*, 111 S.Ct. 2524, 2534 (1991).¹⁶

The Secretary's longstanding interpretation is not irrational or inconsistent—with the terms of the regula-

¹⁶ The courts of appeals have uniformly recognized that deference to the Secretary's interpretation of the regulations implementing Medicare's complex reimbursement scheme is particularly appropriate. *Butler County Memorial Hosp. v. Heckler*, 780 F.2d 352, 356 (3d Cir. 1985); *Mercy Hosp. v. Heckler*, 777 F.2d 1028, 1031 (5th Cir. 1985); *University of Cincinnati v. Heckler*, 733 F.2d 1171, 1173-1174 (6th Cir. 1984); *Abbott-Northwestern Hosp., Inc. v. Schweiker*, 698 F.2d 336, 340 (8th Cir. 1983); *Cheshire Hosp. v. New Hampshire-Vermont Hosp. Serv., Inc.*, 689 F.2d 1112, 1117 (1st Cir. 1982). See also *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 90 (1966) ("Congress [gave] * * * the Secretary very broad discretion in prescribing regulations on [Medicare] * * *, contenting itself with the statement of principles and factors by which his judgment should be guided rather than specification of rules to constrain his discretion.").

tions.¹⁷ It should therefore be upheld. See, e.g., *North Haven Board of Education v. Bell*, 456 U.S. 512, 538 n.29 (1982) ("In construing regulations, the Court normally defers to the agency's interpretation."); *Ford Motor Credit Co. v. Milhollin*, 444 U.S. 555, 565 (1980) (agency interpretation of its own regulation upheld "[u]nless demonstrably irrational"). The court of appeals erred in failing to respect that fundamental proposition.

2. Respondent asserts (Br. in Opp. 10-11) that even if the regulations do not require use of GAAP in determining *whether* costs will be reimbursed, they do require use of GAAP with respect to the *timing* of reimbursement. The regulations provide utterly no support for that claimed distinction. They speak only of "[s]tandardized * * * accounting * * * and reporting practices" (42 C.F.R. 413.20(a)) and of "the accrual basis of accounting" (42 C.F.R. 413.24(a)). If, as respondent further claims (Br. in Opp. 15), the regulations require the Secretary to apply GAAP in making Medicare reimbursement determinations, they provide no basis for her to distinguish, in doing so, between "characterization" and "timing" issues.

¹⁷ The Secretary's interpretation of the relationship of GAAP to her guidelines and policies is reflected not only in the Provider Reimbursement Manual (App., *infra*, 1a), but also in rulemaking proceedings concerning reimbursement rules relating to equity capital. In issuing such rules in 1976, the Social Security Commissioner explained that "generally accepted accounting principles are applicable to Medicare cost determinations *only* when a cost situation is not covered by [the regulations] or the *Provider Reimbursement Manual*. It is only in the absence of health insurance program policy that generally accepted accounting principles should be followed." 41 Fed. Reg. 46,292 (1976)(emphasis added). See also *American Medical Int'l, Inc. v. Secretary of HEW*, 466 F. Supp. 605, 624 n.21 (D.D.C. 1979), *aff'd*, 677 F.2d 118 (D.C. Cir. 1981).

More importantly, the issue of *when* a cost relates to the provision of patient care is as fundamental to the Medicare reimbursement scheme as the determination of *whether* it relates to patient care at all. Under the "reasonable cost" system of payment, the Secretary reimburses providers on an annual basis, based upon review of the provider's year-end "cost report." 42 C.F.R. 413.64 During the fiscal year, the Secretary makes interim, estimated payments to providers. 42 C.F.R. 413.64(b). At the end of the year, the provider submits a detailed report, setting forth those costs for which it claims reimbursement. Based upon an evaluation of the cost report under the relevant "cost finding" and "apportionment" principles, the Secretary makes a retroactive adjustment to "determine[] the Medicare reimbursement for the actual services provided to beneficiaries during the period." 42 C.F.R. 413.60(b) (emphasis added). See also 42 C.F.R. 413.60 (a) and (c). The regulation governing "reasonable cost" reimbursement specifically defines this retroactive adjustment as "the difference between the amount received by the provider during the year for covered services from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year." 42 C.F.R. 413.9(b)(1) (emphasis added). See generally *Good Samaritan Hosp. v. Shalala*, 113 S.Ct. at 2155-2156, 2159-2162; *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399, 400-401 (1988). In calculating the amount of reimbursement due a Medicare provider, it is necessary to determine which costs may properly be reimbursed for that—and only that—cost year.

A central concern of "reasonable cost" reimbursement is thus that any costs "allowed" under Medicare must be

properly matched to services provided to the program's beneficiaries during the applicable period. See, e.g., 42 C.F.R. 413.24(d) (cost finding methods "to determine the actual costs of services furnished during that period"); 42 C.F.R. 413.130(c) (amortization of capital improvement costs); 42 C.F.R. 413.134-413.144 (depreciation of capital assets).¹⁸ With respect to allowable costs that relate to more than one accounting period—such as capital costs from which benefits will be derived over several periods—proper periodic allocation is necessary if Medicare is to pay only that portion of the overall costs that relate to use of hospital facilities by Medicare patients during the period in question.¹⁹

In the context of the Medicare program, it is the responsibility of the Secretary to determine how legitimate costs that generate long-term benefits should be allocated among reporting periods. *Research Medical Center v. Schweiker*, 684 F.2d 599, 602-603 (8th Cir.

¹⁸ This mandate is reflected in the statutory and regulatory prohibitions against "cross-subsidization" of costs between Medicare and non-Medicare patients. See page 5, *supra*; 42 U.S.C. 1395x(v)(1)(A)(i); 42 C.F.R. 413.5 (a), 413.9(a) and (c)(3). This principle also dates from the outset of the Medicare program. See *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 55 (1966). See also *id.* at 48, 91, 197.

¹⁹ An inappropriate shifting of costs among reporting periods could significantly affect the costs properly borne by Medicare. For example, if a provider's Medicare utilization rate (i.e., the ratio of Medicare patient-days to the total number of patient-days within the facility) fluctuated significantly from period to period, or if the provider chose to withdraw entirely from the program before all benefits of a previously-incurred cost were realized, the costs appropriately borne by Medicare would be significantly altered. The Administrator noted that specific concern in his ruling in this case. See Pet. App. 49a.

1982). The Administrator explained in this case that the advance refunding loss recognized by respondent for financial reporting purposes in 1985 represented costs associated with providing health care services throughout the remaining life of the old financing arrangement and should therefore be amortized over the remaining term of the old bonds for purposes of Medicare reimbursement. Pet. App. 47a-51a. The Administrator concluded that the guidelines of PRM § 233 should be applied to this case because amortization of the refunding loss "will more accurately allocate the Provider's refinancing costs, and at the same time, more accurately reflect its current period costs." Pet. App. 51a. Moreover, "[b]y amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases." *Id.* at 49a. The agency's choice of amortization in this context is thus related specifically to the need properly to match reimbursement with *varying levels* of provider service over time. See note 18, *supra*. That concern, of course, played no role in development of the GAAP rule for financial accounting of advance refunding transactions in APB Opinion 26.²⁰ Cf. *Thor Power Tool Co. v. Commissioner*, 439 U.S. at 542. As the courts below both concluded, the Administrator's determination reasonably implements Medicare funding

²⁰ The discussion in APB Opinion 26, ¶¶ 5-8, of the various different methods that were "generally accepted" for financial accounting of "refundings transactions" prior to its adoption demonstrates that more than one rational, and reasonable, accrual accounting method may be applied to this issue. See J.A. 64-67.

principles and is not arbitrary or irrational. Pet. App. 8a-9a; *id.* at 32a.

The conclusion that the costs at issue are to be apportioned over the period remaining prior to repayment of the old bonds is specifically justified under the facts of this particular case. As a result of the refinancing, respondent estimates that it will save more than \$12 million in interest payments over the remaining life of the 1972 and 1982 bonds. J.A. 76; Admin. Rec. 189. The principal benefits of that reduction relate to accounting periods *subsequent* to 1985. See Pet. App. 47a-49a; J.A. 17, 76; Admin. Rec. 312. Although respondent reported this transaction as an "extraordinary loss" on its books in 1985, it did not experience an immediate, unreimbursed outflow of funds, requiring a significantly increased level of Medicare reimbursement for that year. Instead, respondent's cash requirements for the refunding were met by the proceeds of the 1985 bonds and the various debt service funds previously required under the 1972 and 1982 bonds that were released as a result of the 1985 defeasance. See J.A. 20-21 (all "out-of-pocket" costs "financed * * * from borrowing"); J.A. 93, 97. Indeed, as a result of the defeasance (and the corresponding release of funds previously required under the 1972 and 1982 bonds), respondent was able to purchase certain additional capital assets and make improvements to its facility in that year. Admin. Rec. 192, 211-213. As the Secretary concluded, the financial accounting loss experienced by respondent did not require significantly increased reimbursement but "was merely an adjustment [of its] capital structure which enabled [it] to substitute less expensive financing for its existing more expensive financing" and "did not relate exclusively to patient care

services rendered in the year of the loss." Pet. App. 48a-49a.

Both as a programmatic matter for Medicare reimbursement determinations and as a factual matter in this case, the Secretary's conclusion that respondent's "loss" on defeasance relates to more than one accounting period and requires amortization—to properly match reimbursement with varying patient service levels over time—is neither arbitrary, capricious nor an abuse of discretion. 5 U.S.C. 706(2)(A). See *Rust v. Sullivan*, 500 U.S. 173, 184 (1991); *Sullivan v. Everhart*, 494 U.S. 83, 88-89, 93-95 (1990). The court of appeals did not dispute that conclusion. Pet. App. 8a.

The court of appeals instead held the Secretary's order invalid solely because the court concluded that the concededly rational treatment of the particular costs at issue here was precluded by what the court believed to be a "flat statement" in the regulations that GAAP is to be followed in all such reimbursement determinations. Pet. App. 6a. As we have explained above, the court erred in discerning any such regulatory requirement. Because the Secretary's reimbursement determination is not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" (5 U.S.C. 706(2)(A)), it should be sustained.

II. SECTION 233 OF THE SECRETARY'S PROVIDER REIMBURSEMENT MANUAL IS A VALID "INTERPRETATIVE" RULE OR STATEMENT OF POLICY UNDER THE APA.

1. The court of appeals' basic error in interpreting the agency's regulations gave rise to its equally erroneous conclusion that Section 233 of the PRM "effects a substantive change in the regulations" and is therefore a "substantive" rule that is "void by reason of

the agency's failure to comply with the Administrative Procedure Act in adopting it." Pet. App. 3a. As we read the court's opinion, that conclusion has no force independent of the court's determination that the Manual provision, which was issued without formal notice or comment,²¹ conflicts with what the court perceived to be a GAAP-based reimbursement requirement embodied in Sections 413.20 and 413.24 of the regulations. As we have explained above, that interpretation of the regulations is in error.

²¹ Although PRM Section 233 was issued without publication in the Federal Register, it is incorrect to claim that it was issued without any input from the Medicare provider community. Indeed, the record indicates that, in 1981, prior to issuance of PRM Section 233, the government met with representatives of the Blue Cross And Blue Shield Association, the Health Care Financial Management Association, the AICPA, the American Hospital Association, the Catholic Health Association of the United States, the Federation of American Hospitals and the accounting firm of Ernst and Whinney concerning this provision. J.A. 7-8. The agency also received comments on a proposed PRM Section 233 from the law firm of Weissberg and Aronson and the Health Care Financing Study Group (a group of investment counselors). *Ibid.* The "overwhelming" nature of the comments from the Medicare provider community was to "object[]" to GAAP treatment of advance refunding gains and losses under Medicare on the ground that the GAAP approach to that issue was overly "conservati[ve]" and "would cause distortions and a mismatching of expenses with the periods benefitted." *Ibid.* An additional concern may have been that the high interest rates of the early 1980s would have resulted in a "gain" for a provider conducting an advance refunding and that recognition of that "gain" in a single year (as GAAP requires) would have resulted in a significant reduction in Medicare reimbursement to providers. In any case, the Secretary conducted "a most intensive prior consultation"—albeit an informal one—with the Medicare provider community prior to issuance of PRM § 233. J.A. 8.

2. There is, moreover, no requirement that the Secretary develop each of the detailed policies and guidelines to be applied in Medicare reimbursement decisions by adopting substantive rules having the force of law. Nothing in the Administrative Procedure Act or in the Social Security Act requires the agency to adopt every minute and detailed reimbursement policy and guideline as a "substantive rule" with the force of law. See, e.g., *NLRB v. Bell Aerospace Co.*, 416 U.S. 267, 293 (1974); *SEC v. Chenery Corp.*, 332 U.S. 194, 202-203 (1947); 1 K. Davis & R. Pierce, Jr., *Administrative Law Treatise* § 6.8 (3d ed. 1994).²² The Secretary is free, as she has elected here, to defend a reimbursement determination issued in conformity with her informal guidelines as a rational application of the statute and existing regulations—or, in the words of 5 U.S.C. 706(2)(A), as not "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."

Because the Provider Reimbursement Manual was not issued with notice and comment and therefore does not have the force and effect of law (see *Chrysler Corp. v. Brown*, 441 U.S. 281, 301-302 (1979)), PRM Section 233 is relevant to this case only because it represents a rational interpretation of the agency's reimbursement regulations and a statement of policy as to how those regulations will be applied in the particular context of advance refunding transactions.²³ As the court stated in

²² The impracticality of any such requirement is evidenced by the volume and variety of the issues addressed by the Manual, which is several hundred pages long and is subject to constant revision and supplementation. See App., *infra*, 1a-2a.

²³ Under the APA, substantive or "legislative" rules lack legal effect if issued without prior notice and the opportunity for public comment. 5 U.S.C. 553(b) and (c). "[I]nterpretative rules" and "statements of policy," however, need not be preceded by notice

Gibson Wine Co. v. Snyder, 194 F.2d 329, 331 (D.C. Cir. 1952), "interpretative rules are statements as to what the administrative officer thinks the statute or regulation means" when applied in particular situations. See also note 23, *supra*. That description of "interpretative rules" conforms perfectly to the Secretary's description of the Provider Reimbursement Manual as providing "guidelines and policies" for reimbursement determinations in particular fact situations. See App., *infra*, 1a. Section 233 of the Manual also could be said to be within the class of "general statements of policy" that may be issued without notice and comment (5 U.S.C. 553(b)(A)). This Court has described "general statements of policy" as "statements issued by an agency to advise the public prospectively of the manner in which the agency proposes to exercise a discretionary power." *Lincoln v. Vigil*, 113 S. Ct. at 2034, quoting *Chrysler Corp. v. Brown*, 441 U.S. at 302 n.31.

and comment. 5 U.S.C. 553(b)(A). See, e.g., *Lincoln v. Vigil*, 113 S. Ct. 2024, 2033 (1993).

Courts have recognized that the categories of "interpretative" as opposed to "substantive" rules "have 'fuzzy perimeters' and establish 'no general formula.'" *Batterton v. Marshall*, 648 F.2d 694, 702 (D.C. Cir. 1980) (footnote omitted). To make the distinction, the courts have asked whether the rule "impos[es] a new substantive obligation," *McCown v. Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), cert. denied, 479 U.S. 1037 (1987), or creates "new law, rights or duties." *Friedrich v. Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), cert. denied, 498 U.S. 817 (1990) (quoting *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985)). If so, it is substantive. Cf. *Chrysler Corp. v. Brown*, 441 U.S. 281, 301-302 & n.31 (1979); *Batterton v. Francis*, 432 U.S. 416, 425 (1977). Interpretative rules, on the other hand, "merely clarify or explain existing law or regulations." *Seldovia Native Ass'n v. Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990).

The Secretary's regulations already provide ample "legislative authority" for reimbursement of bond issuance costs incurred by providers and the allocation of such reimbursement to particular periods to properly match the services provided to Medicare beneficiaries during those periods. The regulations authorize reimbursement of "capital-related costs" that are "appropriate and helpful in * * * maintaining the operation of patient care facilities." 42 C.F.R. 413.9(b)(2); see generally 42 C.F.R. 413.130-413.157. Such costs include "[n]ecessary and proper interest" and other costs associated with capital indebtedness. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153(a)(1) and (b). The regulations also require that allowable costs be related to beneficiary care. 42 C.F.R. 413.5(a), 413.9; see 42 U.S.C. 1395x(v)(1)(A)(i).

The regulations do not, however, spell out how otherwise allowable bond-issuance costs, which are normally amortized over the life of the bonds to which they relate, should be treated when the liability to which they relate is removed from the provider's books by an advance-refunding transaction. Nor do they make clear how other costs of such a refunding should be allocated among reporting periods to maintain a proper relationship to the varying levels of beneficiary care provided over time. The Provider Reimbursement Manual exists to provide detailed guidance in exactly such situations, and Section 233 provides the specific guideline applicable to the facts of this case. As the Administrator stated in this case, Section 233 is "interpretive of 42 C.F.R. 405.451, 'Cost Related to Patient Care' [now 42 C.F.R. 413.9] which requires payments to be based on 'the actual cost of services rendered to beneficiaries during the year.' Th[e] policy [of PRM § 233] more accurately reflects the economic reality of a bond refunding on the

cost of furnishing services to Medicare beneficiaries than does APB No. 26." Pet. App. 47a.

The guideline provided by PRM § 233 thus "merely * * * elaborate[s] on what is already contained in the regulations." *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201, 1210 (5th Cir. 1980). As a rational elaboration of the reimbursement regulations and the Medicare statute, PRM § 233 was validly applied by the Secretary in this case.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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APPENDIX

The Foreword to the Medicare Provider Reimbursement Manual, U.S. Department of Health and Human Services, pp. I-II, states, in its entirety:

This manual provides guidelines and policies to implement Medicare regulations which set forth principles for determining the reasonable cost of provider services furnished under the Health Insurance for the Aged Act of 1965, as amended. These "Principles of Reimbursement for Provider Costs" have been published in HIRM-1. The provisions of the law and the regulations are accurately reflected in this manual, but it does not have the effect of regulations.

The Social Security Administration (SSA) also publishes quarterly the "Social Security Rulings" under the authority of the Commissioner of Social Security for the purpose of making available official rulings relating to the health insurance program and the other programs under his jurisdiction. The rulings contain appeals case decisions, as well as statements of policy and interpretations of the law (title XVIII of the Social Security Act-Medicare) and regulations which have precedential effect.

Rulings are intended to exemplify general manual instructions and do not alter existing policy guidelines. However, they may place more emphasis on a particular program area that has been identified as a problem. The rulings do not have the force and effect of a statute or regulation, but provide illustrative case material useful in interpreting and applying policies and procedures contained in instructional issuances.

(1a)

The procedures and methods set forth in this manual have been devised to accomodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished. The manual contains informational and procedural material on various aspects of the determination of cost and to assist providers in preparing annual cost reports. The provider's intermediary will issue any necessary supplementary instructions as appropriate for local guidance on items relating to cost determination. For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied.

Under generally accepted accounting principles, or under the "Principles of Reimbursement for Provider Costs" there may be more than one method for handling a particular cost item; in such case the method elected by the provider must be consistently followed in subsequent reporting periods. A change of method must be approved by the intermediary (or SSA for providers dealing directly with the Government) on a prospective and not retroactive basis. Where the manual sets a time limit for requesting such change, or limits the number of changes, the provider and intermediary will be guided by the manual instructions.

The manual accommodates new pages or revisions as further interpretations of the regulations and changes in procedures and methods are made. Accordingly, revised sections, pages, or chapters are issued as necessary. Brackets in the margin of the page indicate new or changed material.

Questions by a provider on cost policies and procedures in the program should be referred to the provider's intermediary.

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QUESTIONS PRESENTED

Respondent modifies Petitioner's characterization of the questions presented as follows:

1. Whether general Medicare reimbursement regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite a contrary administrative rule issued by the Secretary of Health and Human Services to govern reimbursement of advance refunding losses.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in delaying full reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act and the Medicare statute.

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No. 93-1251

In The
Supreme Court of the United States
October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF FOR THE RESPONDENT

STATUTORY AND REGULATORY PROVISIONS INVOLVED

In addition to the statutes and regulations restated in the Brief for Petitioner ("Pet. Bf."):

1. 42 U.S.C. § 1395hh(a), provides as follows:

(1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.

(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

2. The Medicare regulation implementing 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. Part 413, provides in pertinent part as follows:

Subpart A - Introduction and General Rules

§ 413.5 Cost Reimbursement: General

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. * * *

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement. * * *

STATEMENT OF THE CASE

Resolution of the questions presented in this case involves very few disputed points. There is no dispute between the parties as to the amount of Respondent's loss on advance refunding. Pet. Bf. 8, Joint Appendix ("J.A.") 26. It is also undisputed that this loss is a reimbursable cost under the Medicare program. Appendix to Petition for Writ of Certiorari ("Pet. App.") 2a. The parties likewise are in agreement that no Medicare regulations specifically address the reimbursement effect of an advance refunding loss. Pet. App. 20a. There is further no question that Petitioner's treatment of Respondent's advance refunding loss, as embodied in section 233 of the Provider Reimbursement Manual ("PRM"), is inconsistent with the immediate recognition of such a loss required according to generally accepted accounting principles ("GAAP"). Pet. Bf. 9, 10. The parties recognize that Respondent claimed Medicare reimbursement for its advance refunding approach consistent with this GAAP approach. Pet. Bf. 9. Finally, it is undisputed that the one other circuit

court addressing the proper Medicare treatment for an advance refunding loss, and all of the six other district courts similarly deciding the precise issue presented here, have determined that Petitioner is required by her own regulations to reimburse providers for these losses in the year of defeasance according to the GAAP approach.¹

Because there is no question in this case that Respondent's loss on advance refunding is a reimbursable cost, the courts below concluded that the sole issue presented concerns the correct timing of reimbursement. As the U.S. Court of Appeals for the Sixth Circuit determined:

It is undisputed that the hospital is entitled to reimbursement for reasonable advance refunding costs. There is a dispute, however, as to when and how reimbursement is to be made – in

¹ These cases, surprisingly not mentioned in Petitioner's Brief although discussed in her Petition for Writ of Certiorari at notes 7 and 9, are: *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994) (Appendix to Supplemental Brief for the Respondent in Opposition to Petition ("Supp. App.") A1-A13); *Methodist-Evangelical Hosp., Inc. v. Shalala*, 1993 WL 548830, CCH Medicare & Medicaid Guide ¶ 42,017 (D.D.C. Dec. 22, 1993); *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D. Ill. 1993); *St. John Hosp. v. Shalala*, CCH Medicare & Medicaid Guide ¶ 41,700 (E.D. Mich. Aug. 18, 1993); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hosp. v. Sullivan*, 1991 WL 104090, CCH Medicare & Medicaid Guide ¶ 40,227 (D. Me. April 25, 1991); *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985). See also *Henry County Memorial Hosp. v. Shalala*, 1994 WL 141973, CCH Medicare & Medicaid Guide ¶ 42,129 (S.D. Ind. Feb. 23, 1994) (court applies Medicare regulations and GAAP to recognize advance refunding gain in year of refinancing). Needless to say, there is no "conflict" among the federal courts on this issue as is suggested in the Petition at pages 11 and 14 n.9.

a lump sum payable now, or in a series of payments stretched over the remaining life of the original bonds?

Pet. App. 2a. Likewise, the U.S. District Court for the Southern District of Ohio noted: "[t]he parties agree that the refinancing cost incurred by Guernsey Hospital is a cost which is reimbursable. * * * As noted above, the disagreement involves the timing of reimbursement." Pet. App. 19a-20a.

Respondent takes issue with Petitioner's characterization of the loss on Respondent's advance refunding as merely an "accounting" loss. Pet. Bf. 8.² Respondent incurred an actual loss at the time of its advance refunding in 1985. This loss included Respondent's payment of a call premium in the amount of approximately \$300,000 into the trusted escrow account for early retirement of

² Petitioner's claim that Respondent's advance refunding loss is only an "accounting" loss seems contrary to her position that such a loss is a reimbursable cost under the Medicare program. In any event, the courts have also rejected this notion.

The Secretary finally argues that the Hospital's loss was not a cash loss but only a "paper" loss, suggesting that the Hospital has not, in fact, incurred any real costs attributable to Medicare reimbursement. I disagree. The Hospital incurred a larger debt from the second bond issue than from the first, as well as up-front costs related to the transaction. In addition, the loss incurred as a result of the advance refunding has weakened the Hospital's debt-to-equity ratio and may have placed it in a less desirable position for obtaining future financing. Consequently, the Hospital has indeed incurred present debt and related costs.

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,600-36,601.

the 1982 bonds in 1992. J.A. 15, 16. The advance refunding loss also included the Respondent's write-off of approximately \$700,000 for its unamortized bond discount and financing costs associated with the 1972 and 1982 bonds (the "refunded bonds"). These costs, which Respondent actually paid in connection with the refunded bond transactions, include bond underwriter discounts, attorney and accountant fees, and feasibility study costs. J.A. 15. These two components of the loss were netted against the interest earned on escrow account funds to calculate the actual loss amount of \$672,581. J.A. 16, 26. The Medicare portion of this loss at issue here is approximately \$314,000. Pet. App. 4a.

Petitioner acknowledges that the advance refunding saved Respondent more than \$12 million in debt service costs associated with the refunded bonds. Pet. Bf. 8. This savings, in the amount of \$12,112,029, results from the lesser total interest expense for the Hospital Improvement Revenue Refunding Bonds, Series 1985 (the "refunding bonds") as compared to the sum total interest expense which Respondent would have had to pay for the refunded bonds. J.A. 76. The Medicare program also benefits from this substantial reduction in Respondent's debt service expenses since it means a corresponding decrease in Respondent's reimbursable interest costs. J.A. 14.

The advance refunding transaction discharged Respondent from any further obligation for the refunded bonds. Upon issuance of the refunding bonds, \$16,011,200 was irrevocably deposited into an escrow fund which BancOhio National Bank, Ohio maintained as trustee for the benefit of the bondholders. J.A. 39-47. With the payment of that sum into the escrow account, the City of

Cambridge, the trustee and Respondent executed a release, dated February 27, 1985, whereby Respondent was discharged from any further obligations regarding the refunded bonds. J.A. 50-53; 9-11. Respondent's 1985 audited financial statements and tax return both report the full amount of the advance refunding loss. J.A. 12-14. Respondent's financial statements after 1985 make no mention of either the refunded bonds or the loss on advance refunding. J.A. 14-15.

Upon the advance refunding, the refunded bonds became an obligation of the trustee. The escrow agreement requires the trustee to apply the escrowed funds to pay bondholders principal and interest on the refunded bonds when due. J.A. 39-47. These future debt service payments are costs of the trustee and will be reported in the financial statements related to the trustee. J.A. 24-25.

PRM § 233 bound Community Mutual Insurance Company, the fiscal intermediary of Petitioner, to amortize Respondent's refinancing loss over the remaining life of the refunded bonds. Pet. App. 87a. The fiscal intermediary had no discretion to deviate from this reimbursement treatment for the loss on advance refunding. Admin. Rec. 357, 358. Petitioner failed to promulgate PRM § 233 with public notice and comment as prescribed under the Administrative Procedure Act ("APA"), 5 U.S.C. § 553. Pet. Bf. 36.

Respondent and the fiscal intermediary adjudicated their dispute in an evidentiary hearing before the Provider Reimbursement Review Board ("PRRB"). 42 U.S.C. § 1395oo(h), in pertinent part, provides: "[t]he Board [PRRB] shall be composed of five members * * *. All of the members of the Board shall be persons knowledgeable in the field of payment of providers of services, and

at least one of them shall be a certified public accountant." At the PRRB adjudication hearing, Respondent offered the testimony of Donald Huelskamp, C.P.A., the hospital's vice president of finance and chief financial officer, and Douglas Langenfeld, C.P.A., partner with the accounting firm of Ernst & Whinney (now Ernst & Young). Diane Andrews, audit supervisor, testified on behalf of the fiscal intermediary.

Respondent takes issue with Petitioner's statement that the PRRB did not directly address PRM § 233 in its decision. Pet. Bf. 10. The PRRB specifically observed that "PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component." Pet. App. 70a. The PRRB unanimously found in favor of Respondent and held as follows:

The Board, after considering the facts, the parties' position papers, the evidence presented, the testimony at the hearing, and post-hearing briefs, finds that the Provider [Respondent] is entitled to take the full loss on the advance refunding of the [refunded] bonds in FY. [fiscal year] [19]85. The Board finds that the loss on defeasance is an allowable cost under 42 CFR 405.451 [redesignated as 42 C.F.R. § 413.9] and is to be reimbursed in its entirety in the fiscal year at issue. Under GAAP, the loss on defeasance was a cost incurred in FY 85. This accounting treatment conforms with the requirement found in: (1) 42 CFR 405.406 [42 C.F.R. § 413.20] - providers are to follow standardized accounting practices; and (2) 42 CFR 405.453 [42 C.F.R. § 413.24] - providers are to furnish adequate

cost data based on the accrual method of accounting.

Pet. App. 69a.³

In its decision, the PRRB also directly addressed Petitioner's argument that the "economic realities" of the refinancing transaction require amortization. The PRRB first found that Respondent's advance refunding loss must be recognized in 1985 since this loss is tied to past periods in which the hospital was obligated under the refunded bonds, not future periods. Pet. App. 71a. The PRRB further determined that not only is Petitioner's economic reality argument without foundation in the Medicare regulations, but that Petitioner has asserted very different positions on this issue in the past.

The problem with this approach is that while beguiling (who would want to be caught espousing economic unreality?!) it is not a principle embodied in any regulation nor is it required by statute. * * *

Further, HCFA [the Health Care Financing Administration] has consistently rejected the

³ The PRRB's ruling in this case is consistent with its twelve other decisions addressing this precise issue. The PRRB decided in favor of the provider in each of the seven federal court decisions mentioned in note 1 above. The PRRB also ruled in favor of the provider in the following other advance refunding cases: *Dominican Santa Cruz Hosp., Santa Cruz, Ca. v. Blue Cross, CCH Medicare & Medicaid Guide ¶ 40,120* (PRRB Aug. 16, 1990); *Michigan Osteopathic Medical Ctr. v. Shalala, CCH Medicare & Medicaid Guide ¶ 40,369* (PRRB June 18, 1992); *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Ass'n, CCH Medicare & Medicaid Guide ¶ 40,413* (PRRB Sept. 6, 1991); *St. Mary's Regional Medical Ctr. v. Aetna Life Ins. Co., CCH Medicare & Medicaid Guide ¶ 41,583* (PRRB July 1, 1993); and *Univ. of Michigan Hosps. v. Blue Cross & Blue Shield Ass'n, CCH Medicare & Medicaid Guide ¶ 41,743* (PRRB Sept. 23, 1993).

concept of economic reality argued by providers in cases regarding recapture of depreciation. In both the old and amended versions of the regulation providing for recapture of depreciation, HCFA has adopted a policy treatment which exactly coincides with that of GAAP. * * * Thus, the Administrator himself is inconsistent in his acceptance of and approach to the concept of economic reality.

Pet. App. 70a-80a.

In addition, the PRRB recognized the importance of having an accepted and consistent approach to reimbursement such as the one embodied in GAAP:

It is clear then that if, in the absence of any defining regulation, a concept of economic reality was used to measure costs, the result would be reimbursement schizophrenia, with each provider and intermediary applying their own personal concept of economic reality. The wisdom of adopting some common measurement of costs such as GAAP (which the Secretary appears to have done in 42 CFR 405.406 [42 C.F.R. § 413.20]) is thus self-evident. The principles of GAAP are carefully defined and are thus less open to interpretation than an undefined concept of economic reality.

Pet. App. 80a.

By decision dated October 12, 1990, the HCFA Deputy Administrator reversed the ruling of the PRRB. Pet. App. 40a-53a. The Discussion and Evaluation section of this opinion makes no mention of either 42 C.F.R. §§ 413.20 or 413.24, the two regulations which the PRRB had found directed application of the GAAP approach in this case. While the Deputy Administrator did note that

"GAAP will usually provide a reasonably accurate calculation of the cost of delivering health services to a provider's patients," he concluded that the specific policy set forth in PRM § 233 compelled a different treatment. Pet. App. 45a-46a.

Based on a strained reading of the Medicare regulations and GAAP, the district court affirmed the decision of the Deputy Administrator. Focusing its analysis on 42 C.F.R. § 413.20, the district court concluded that, while providers are required to report their costs based on GAAP, Petitioner need not also reimburse providers based on the same principles when no regulation governs the cost at issue. Pet. App. 31a.

The district court further asserted that: "[i]f the evidence of record suggested that rational accountants could not disagree on this point, and that the only possible way of treating this cost was to recognize it in full in the year in which it was incurred, the Secretary's decision might be said to be arbitrary." Pet. App. 33a. What the district court failed to realize was that the record evidence did plainly indicate that rational accountants cannot disagree on the proper treatment of a loss on advance refunding. This treatment is mandated in *Early Extinguishment of Debt*, Accounting Principles Board Opinion No. 26 (1972) ("APB 26") which specifies that refinancing losses must be recognized in full in the year of the refinancing. J.A. 62-75. Accountants are without authority to express an unqualified opinion which contradicts APB 26. J.A. 21.

In a unanimous opinion, the court of appeals reversed the district court. The court of appeals determined that the applicable regulations require Petitioner to apply GAAP for reimbursement of advance refunding losses.

Were it not for § 233 of the Provider Reimbursement Manual, any fair-minded person reading the regulations in the light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Pet. App. 8a.

The court of appeals also rejected the notion that GAAP must be applied for cost reporting, but not cost reimbursement, purposes. The court of appeals concluded that there must be consistency between cost reporting and cost reimbursement so that the provider industry will know its costs of delivering medical services to program beneficiaries and will be able to predict reimbursement. Pet. App. 13a. The court of appeals went on to hold as follows:

The "nexus" that exists in the regulations between cost reporting and cost reimbursement is too strong, in our view, to be broken by a rule not adopted in accordance with the rulemaking requirements of the Administrative Procedure Act. Insofar as the decision issued by the district court in this case holds otherwise, the decision is reversed.

Pet. App. 13a. Petitioner's petition for rehearing was denied as no judge from the Sixth Circuit voted in favor of granting the same. Pet. App. 38a-39a.

SUMMARY OF ARGUMENT

The parties agree that the loss Respondent incurred through the advance refunding is a reimbursable cost under the Medicare program. The dispute in this case is

whether the applicable Medicare statutes, regulations and case law construing these provisions permit Petitioner to postpone payment for this reimbursable cost based on a PRM provision which issued without public notice and comment.

While typically an interpretation of Petitioner would be subject to deference on judicial review, such deference is not appropriate here. Since PRM § 233 defies the plain language of 42 C.F.R. §§ 413.20, 413.24 and 413.5, the Secretary's interpretation is entitled to no deference. Similarly, because the Secretary's interpretation turns on a question of law and is inconsistent with both the PRRB's conclusions and former positions of the Secretary, administrative deference is diluted.

42 U.S.C. § 1395x(v)(1)(A) compels the Secretary to promulgate by regulation her reimbursement methods and the items to be included as reimbursable costs under the Medicare program. The Secretary has promulgated no such regulation defining her method of reimbursement for advance refunding losses. The Medicare statute further directs the Secretary to consider reimbursement principles generally applied by national organizations in prescribing her reimbursement regulations. The American Hospital Association, one such national organization discussed in the legislative history of this statutory language, applies GAAP for cost reimbursement purposes.

The Sixth Circuit correctly applied the plain language of sections 413.20, 413.24 and 413.5 in determining that Respondent was entitled to reimbursement for the full Medicare portion of its advance refunding loss in 1985. Section 413.20 indicates that GAAP "are followed" and

changes in these practices will not be required to "determine costs payable under the principles of reimbursement." The GAAP approach requires current recognition of Respondent's loss in the year of the advance refunding. Section 413.24 further requires that a provider's costs be recognized "in the period in which they are incurred * * * ." Respondent's advance refunding loss was "incurred" in 1985 according to GAAP. Finally, section 413.5 specifies that one of the "goals" of Medicare reimbursement principles is "current payment" of providers for their reimbursable costs.

PRM § 233 defies the plain language of sections 413.20, 413.24 and 413.5. Section 233 amortizes the advance refunding loss over the remaining life of the refunded bonds even though the refunded bonds are no longer on the books of Respondent and the hospital has been released from any further obligation with respect to these bonds. This amortized treatment is contrary to GAAP and fails to reimburse Respondent currently when its advance refunding loss was incurred.

The decision of the court of appeals that section 233 impermissibly amends the plain language of the Medicare regulations is consistent with all seven other federal court decisions which are precisely on point. *Mother Frances Hosp.*, 15 F.3d 423; *Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017; *Graham Hosp.*, 832 F. Supp. 1235; *St. John Hosp.*, CCH Medicare & Medicaid Guide ¶ 41,700; *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227; *Baptist Hosp.*, 767 F. Supp. 139; and *Ravenswood Hosp.*, 622 F. Supp. 338.

Finally, PRM § 233 constitutes an invalid "substantive" rule under both the APA and the Medicare statute.

Section 233 affects the reimbursement rights of Respondent and has been enforced as a rule of law to deny Respondent current payment for its otherwise reimbursable advance refunding loss. Section 233 further makes a substantive change in Petitioner's methods of reimbursement, the items included as reasonable costs and the scope of benefits under the Medicare program. Section 233 "interprets" no Medicare regulation or statute. While the Secretary undoubtedly has the authority to promulgate section 233 through public notice and comment as a regulation, her "problem, of course, is that she has not done so." Pet. App. 9a. PRM § 233 is therefore invalid and the court of appeals' decision should be affirmed.

ARGUMENT

Standard of Review

The APA standard of judicial review applies to decisions of Petitioner. 42 U.S.C. § 1395oo(f)(1). Under the APA, reviewing courts are to "hold unlawful and set aside agency action, findings, and conclusions found to be (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; * * * (D) without observance of procedures as required by law; [or] (E) unsupported by substantial evidence." 5 U.S.C. § 706(2).

While Petitioner's regulatory interpretations normally are entitled to deference on review, this deference is not appropriate in this case. The "deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia * * * ." *Am. Ship Building Co. v. N.L.R.B.*, 380 U.S.

300, 318 (1965).⁴ There are a number of critical reasons why such deference to Petitioner's interpretation is not applicable here.

First, an agency interpretation, such as PRM § 233, cannot contravene the express wording of the agency's own regulations. The weight typically given to an agency interpretation obviously cannot apply where the interpretation is "inconsistent with the regulation." *Stinson v. U.S.*, ___ U.S. ___, 113 S.Ct. 1913, 1919 (1993). See *Public Employees Retirement Sys. of Ohio v. Betts*, 492 U.S. 158, 171 (1989) ("[N]o deference is due to agency interpretations at odds with the plain language of the statute itself. Even contemporaneous and longstanding agency interpretations must fall to the extent they conflict with statutory

⁴ As the First Circuit asserted in *Mayburg v. Secretary of Health and Human Services*, 740 F.2d 100, 105 (1st Cir. 1984) (Breyer, J.):

A different line of Supreme Court cases, however, cautions us that "deference" is not complete; sometimes a different, and more independent judicial attitude is appropriate. *Bureau of Alcohol, Tobacco & Firearms v. Federal Labor Relations Authority*, [464] U.S. [89], [97] (1983) (court reviewing agency interpretation of law should not "slip into judicial inertia" or "rubberstamp" the agency); *American Shipbuilding Co. v. NLRB*, 380 U.S. 300, 318 (1964) (deference owed to agency "cannot be allowed to slip into a judicial inertia"); *NLRB v. Brown Food Store*, 380 U.S. 278, 291 (1964) (reviewing courts "are not obliged to stand aside and rubber stamp" the agency); *NLRB v. Insurance Agents' International Union*, 361 U.S. 477, 499 (1960) (recognition of administrative power "cannot exclude all judicial review" of agency's actions); see also *NLRB v. Highland Park Manufacturing Co.*, 341 U.S. 322, 325-26 (1951); *Davies Warehouse Co. v. Bowles*, 321 U.S. 144, 156 (1944). (parallel citations deleted).

language."); *Presley v. Etowah Cty. Comm'n*, ___ U.S. ___, 112 S.Ct. 820, 832 (1992). In the Medicare context, "[w]here a PRM provision exceeds its purpose and conflicts with an existing regulation or statute, it is invalid under the APA." *Mercy Hosp., CCH Medicare & Medicaid Guide* ¶ 40,227 at 30,602.

For this reason, reviewing courts must closely compare the wording of the regulation and the agency's interpretation.

[W]e must "examine the interpretation itself in light of the language of the regulations. The words must be reasonably susceptible to the construction placed upon them by the Secretary, both on their face and in light of their prior interpretation and application. The interpretation must sensibly conform to the purpose and wording of the regulations."

St. Elizabeth Community Hosp. v. Heckler, 745 F.2d 587, 592 (9th Cir. 1984) (citations omitted). The Sixth Circuit similarly has asserted:

An administrative agency's interpretation of a regulation is valid, however, only if that interpretation complies with the actual language of the regulation. An agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through changes in interpretation unsupported by the language of the regulation.

Fluor Constructors v. Occupational Safety and Health Review Comm'n, 861 F.2d 936, 939 (6th Cir. 1988) (citations omitted). In this case, of course, Respondent maintains that PRM § 233 is inconsistent with the express wording of the Medicare regulations.

The Medicare regulations are clear and unambiguous regarding the application of GAAP. As the court of

appeals found below: "[t]he rule set forth in the manual ignores the structure of the regulations and assumes the existence of a regulatory ambiguity that we have not been able to detect." Pet. App. 11a-12a. See also *Mother Frances*, Supp. App. A-7 ("In light of GAAP, the manifest conclusion from reading these regulations is that the Hospital was entitled to full reimbursement for this advance refunding loss in 1987."); *Mercy Hospital*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602 ("The Secretary has explicitly promulgated regulations applying GAAP.") As explained in *St. Luke's Hosp. v. Secretary of Health and Human Services*, 810 F.2d 325 (1st Cir. 1987), another reason for rejecting an administrative interpretation arises when the underlying regulations are unambiguous:

[W]e simply read the statute to mean what it says; we interpret the language literally, and we find no initial ambiguity. Furthermore, our detailed analysis convinces us that our initial, literal reading of the words is also consistent with the statute's history and purposes. As the Supreme Court has recently said, "deference" to the agency's view of a statute is appropriate only when the statute is ambiguous.

Id. at 331 (Breyer, J.).

Second, courts review questions of law in administrative proceedings on a *de novo* basis. The APA specifies that "the reviewing court," not the administrative agency, "shall decide all relevant questions of law." 5 U.S.C. § 706. See *Office of Communication of the United Church of Christ v. F.C.C.*, 707 F.2d 1413, 1422 n.12 (D.C. Cir. 1983) ("The APA appears to require *de novo* review of all questions of law * * * .") While judicial resolution of administrative appeals must consider the knowledge gained from agency experience, the "final meaning" to be applied to

statutory and regulatory language is purely the province of the judiciary. *F.T.C. v. Colgate Palmolive Co.*, 380 U.S. 374, 385 (1965). See also *Office of Communication*, 707 F.2d at 1422 ("Traditionally, in determining whether the Commission has acted within its legally delegated authority, courts accord only limited deference to an agency's interpretation of its own governing statute."); *Rose v. Dole*, 945 F.2d 1331, 1333 (6th Cir. 1991); *Phillips Petroleum Co. v. F.E.R.C.*, 786 F.2d 370, 374 (10th Cir. 1986), *cert. denied*, 479 U.S. 823 (1986). The sole question presented in this case, too, involves no disputed facts. Rather, it is a question of law concerning whether Petitioner's interpretation in PRM § 233 is consistent with the Medicare regulations.

Third, it is well established that a final agency determination is more suspect on review if another agency adjudicatory body had previously reached a contrary conclusion. See *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 496 (1951); *Ohio Associated Tel. Co. v. N.L.R.B.*, 192 F.2d 664, 668 (6th Cir. 1951). This doctrine applies in situations such as this where the decisions of the PRRB and HCFA Deputy Administrator differ. As stated in *St. Luke's Hosp. v. Schweiker*, CCH Medicare & Medicaid Guide ¶ 31,501 (E.D. Pa. Aug. 12, 1981):

[T]he fact that the administrator reversed a decision [of the PRRB] reached within the agency is sufficient to require close scrutiny by this court. This is especially so since the PRRB, a five member board, has members which are required by statute to be "knowledgeable" in the field of cost reimbursement. * * * It is not appropriate for the courts to afford the Secretary's position extreme deference.

A similar concern was articulated in *St. John's Hickey Memorial Hosp., Inc. v. Califano*, 599 F.2d 803, 813 n.18 (7th Cir. 1979).

Here the plaintiff is not the beneficiary of the government program, but a necessary participant in carrying out the program. The Secretary is obligated by statute to reimburse all reasonable costs of such providers. It would be inappropriate to allow his subordinate [the HCFA Administrator] to be the final arbiter of what is reasonable, particularly when they have overruled the decision of the Provider Reimbursement Review Board which was set up to mediate disputes between providers and intermediaries acting for the agency.

See also *Sentara-Hampton General Hosp. v. Sullivan*, 980 F.2d 749, 758 (D.C. Cir. 1992) ("[S]ince the HCFA frequently overruled the PRRB's findings, the inconsistency between the PRRB and HCFA 'detracts substantially from the deference normally due an agency's interpretation of its own regulations.'"); *Ornda Healthcorp v. Shalala*, 1993 WL 566004, CCH Medicare & Medicaid Guide ¶ 41,975 (E.D. Ark. Oct. 5, 1993) (Petitioner's "decision is subject to particular scrutiny when, as here, she rejected the decision of the [PRRB].").

Fourth, administrative deference is diluted when the agency has in the past taken a conflicting interpretation to the one currently being advanced. In *Morton v. Ruiz*, 415 U.S. 199, 237 (1974), this Court indicated that "[w]e have recognized previously that the weight of an administrative interpretation will depend, among other things, upon 'its consistency with earlier and later pronouncements' of an agency. In this instance, the [agency's] somewhat inconsistent posture belies its present assertion." (citations omitted). See also *Bowen v. Am. Hosp. Ass'n*, 476

U.S. 610, 646 n.34 (1986) ("The fact that the agency's interpretation 'has been neither consistent nor longstanding substantially diminishes the deference to be given to [the agency's] present interpretation of the statute.'"); *Saint Mary of Nazareth Hosp. v. Schweiker*, 718 F.2d 459, 464 (D.C. Cir. 1983).

Petitioner's argument that the court of appeals erred in determining that she is required to apply GAAP in the absence of a specific regulation to the contrary is inconsistent with the Secretary's position in those cases where GAAP supports a denial of reimbursement. For example, in *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1180 (9th Cir. 1980), "[t]he Secretary refused reimbursement on the ground that under 'generally accepted accounting principles' (which the Secretary is mandated to apply where an issue has not been covered by agency regulations * * *) there were no reasonable costs incurred." The decision in that case further observed that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply 'generally accepted accounting principles.'" *Id.* at 1181 (emphasis added). Thus, Petitioner's position in this action is not only inconsistent with the Medicare cost reimbursement regulations, it defies the Secretary's prior interpretation of those same regulations.⁵

Finally, the reimbursement treatment of an advance refunding loss espoused in PRM § 233 is particularly suspect when considering that every single one of the eight federal courts reviewing this issue have rejected the

⁵ As discussed *infra* at pages 27 and 28 of the text, the Secretary's interpretations of the Medicare regulations at issue have also fluctuated during the course of these proceedings.

amortization approach as inconsistent with the regulations. In perhaps an understatement, the Fifth Circuit noted in *Mother Frances* that "[t]his argument of the Secretary has not fared well in the federal courts." Supp. App. A-7. This uniform judicial rejection of Petitioner's interpretation itself repudiates her deference arguments. See *Mayburg*, 740 F.2d at 102.

The Medicare Statute

The Medicare provisions of the Social Security Act require Petitioner to promulgate by regulation her methods of determining reimbursable program costs. 42 U.S.C. § 1395x(v)(1)(A), in pertinent part, provides:

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs * * * (emphasis added)

Pet. Bf. 2. The obligatory nature of this statute indicates that Petitioner has little choice but to adopt her reimbursable cost methods through the APA as regulations. See *Good Samaritan Hosp. v. Shalala*, ___ U.S. ___, 113 S.Ct. 2151, 2154 n.1 (1993). The parties agree that the Secretary's reimbursement method for advance refunding losses as embodied in PRM § 233 have not been promulgated in any regulation. Pet. Bf. 36.

Section 1395x(v)(1)(A) goes on to state as follows:

In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers.

Regarding this provision, the court of appeals determined that "[w]e can safely assume 'national organizations' keep their books in accordance with 'generally accepted accounting principles.'" Pet. App. 6a.⁶ The court of appeals noted, however, that "[t]he fact that the Secretary must 'consider' GAAP in prescribing her regulations does not mean that GAAP must be adopted in the regulations * * *." *Id.*

Petitioner surprisingly contends that the "principles * * * applied by national organizations or established prepayment organizations" referenced in the Medicare statute "have nothing specifically to do with GAAP." Pet. Bf. 21.⁷ Petitioner claims that she is not even obligated to "consider" GAAP in promulgating her reimbursement regulations. In support of this position, Petitioner refers

⁶ The Fifth Circuit in *Mother Frances* likewise made the self-evident observation that "[t]hese 'national organizations' utilize GAAP." *Mother Frances*, Supp. App. A-6.

⁷ The district court below found that "[t]he Secretary agrees that the Medicare Act requires both reimbursement of reasonable costs and consideration of GAAPs." (emphasis added). Pet. App. 26a.

to certain publications of the American Hospital Association ("AHA"). Pet. App. 21. These publications detract from Petitioner's position instead of bolstering it. The AHA, *Principles of Payment for Hospital Care* (1963), for example, states as one of its fundamental reimbursement principles that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting."⁸ This concept is nearly identical to the language of 42 C.F.R. § 413.20(a), which states "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are followed."

Likewise, the "Purpose and Scope" section of AHA, *Uniform Chart of Accounts and Definitions for Hospitals* (1959) indicates that the AHA has adopted the accrual basis of accounting as is specified pursuant to 42 C.F.R. § 413.24. The Accounting Principles Board, which issued APB 26, was not created until September, 1959, and did

⁸ In her brief, Petitioner acknowledges this principle in *Principles of Payment for Hospital Care* but misconstrues the commentary regarding the same. Pet. Bf. 21 n. 11. Petitioner selectively quotes from this commentary and omits the following two sentences:

Any systematic payment program requires an orderly procedure of reporting in order that the payment program may be administered fairly and expeditiously. . . . Reimbursement at cost by third party agencies is dependent upon their knowledge of the procedures used in providing the data.

Ibid. at 6, 7. This commentary stresses the importance of tying uniform reporting to payment practices so that the reimbursement program will be "systematic" and predictable. The AHA's discussion is similar to the court of appeals' conclusion regarding the strong "nexus" which exists in the regulations between cost reporting and cost reimbursement. Pet. App. 13a.

not issue its first APB Opinion until November, 1962. Dr. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* (7th ed. 1991) p. 1-19. After its creation and the issuance of its pronouncements regarding GAAP, the AHA made clear that GAAP and APB Opinions are the recommended principles of accounting for hospitals.

Use of inconsistent methods of accounting and of procedures adopted as a result of individual inclinations causes confusion and misunderstanding. This chapter therefore is concerned with generally accepted accounting principles recommended for hospitals. The principles and concepts recommended in the *Opinions*, of the Accounting Principles Board and the Committee on Auditing Procedures of the American Institute of Certified Public Accountants (AICPA) and the AICPA *Hospital Audit Guide* should be used as references for specific questions.

AHA, *Chart of Accounts for Hospitals* (Rev. 1973). Thus, the court of appeals was obviously correct in its conclusion that national organizations such as the AHA adhere to GAAP.

Similarly, the comments of former Social Security Commissioner Ball as taken from the legislative history of the Medicare Act do not lend Petitioner the support she seeks. Commissioner Ball acknowledged that "the determination of reimbursable cost does require the acceptance and use of uniform definitions, accounting, statistics, and reporting." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, 89th Cong., 2d Sess. 198 (1966). Commissioner Ball himself therefore noted GAAP's significant role in the development of Medicare payment regulations.

Finally, the legislative history of the Social Security Act indicates that reimbursement principles contrary to

GAAP were rejected. During Congressional consideration of reimbursement principles, "[t]he AHA argued very vigorously for establishing depreciation on a cost-of-replacement basis." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance, 89th Cong., 2d Sess. (1966)*, p. 46. This depreciation method departs from GAAP which adopts a historical cost basis for depreciation. APB Statement No. 4 (1970), ¶ 164. This departure was cited by the Senate Committee on Finance as the ground for rejecting the AHA replacement value depreciation basis. "[A]lthough there was some merit in the argument for a replacement cost basis, the use of this basis was too much a departure from the most common practice." *Reimbursement Guidelines for Medicare: Hearings Before the Senate Comm. on Finance*, p. 46.

The Plain Language of the Medicare Regulations

42 C.F.R. § 413.20

The reimbursement regulations which the Secretary has promulgated pursuant to 42 U.S.C. § 1395x(v)(1)(A) are set forth at 42 C.F.R. Part 413. This part is entitled "Principles of Reasonable Cost Reimbursement * * *" and "sets forth regulations governing Medicare payment for services furnished to beneficiaries * * * ." 42 C.F.R. § 413.1.

42 C.F.R. § 413.20(a) plainly states

(a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. Standardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields are

followed. Changes in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement.

In a curious change of position, Petitioner argues that the "standardized" accounting practices which "are followed" pursuant to section 413.20(a) do not refer to GAAP. Petitioner finds the provision ambiguous and proclaims that "Section 413.20(a) by its terms does not require use of GAAP." Pet. Bf. 27. Before the court of appeals, the Secretary interpreted this provision somewhat differently. The Secretary found that this same regulation: 1) "provides that Medicare providers shall utilize GAAP for reporting their costs to Medicare" (Sec. Ct. App. Bf. 21); 2) "indicates that standardized practices (GAAP) will not need to be changed to participate in Medicare" (*Id.*); and 3) means that "the accounting systems and GAAP will be utilized 'to arrive at an equitable and proper payment for services to beneficiaries.' " (*Id.* at 23).⁹ After arguing below that section 413.20(a) refers to GAAP, Petitioner's contrary assertions now must be given short shrift as "[t]he courts may not accept appellate counsel's post hoc rationalizations for agency

⁹ Besides the seven other advance refunding cases cited in note 1 *supra*, federal courts have systematically interpreted section 413.20 as requiring the Secretary to apply GAAP in the absence of a regulation to the contrary. See *Charlotte Memorial Hosp. and Medical Ctr. v. Bowen*, 860 F.2d 595 (4th Cir. 1988); *HCA Health Services*, 869 F.2d 1179; *Nat'l Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View Community Hosp. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983); *Medical Society of South Carolina v. Heckler*, 1984 WL 48806, CCH Medicare & Medicaid Guide ¶ 33,651 (D.S.C. Feb. 27, 1984). The Secretary's suggestions to the contrary in the PRM uniformly have been rejected on judicial review. Pet. Bf. 30 n. 17.

orders." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988).

It is also important to note that even had Petitioner taken a consistent stance as to the meaning of standardized accounting practices in section 413.20, her position would not be a credible one. As Petitioner notes in her brief, "GAAP consists of principles established by certain 'standard setting organizations' and professional societies. * * * In the absence of an applicable formal standard from one of those organizations, what is 'generally accepted' depends on 'the consensus of the accounting profession' as manifested in treatises and other publications." Pet. Bf. 9 n.6. Respondent submits that there can be no more "widely accepted" or "standardized" accounting practices than GAAP since, by definition, it consists of the principles generally accepted in the profession.

APB 26 is the GAAP controlling the treatment of advance refunding transactions such as the one at issue here. J.A. 62-75. APB 26 was promulgated to address the accounting profession's concerns that similar types of debt extinguishment transactions be dealt with consistently. Pet. App. 32a. APB 26 requires current recognition of both advance refunding losses and gains: "A difference between the reacquisition price and the net carrying amount of the extinguished debt should be recognized currently in income of the period of extinguishment as losses or gains * * *. Gains and losses should not be amortized to future periods." J.A. 71.¹⁰ APB 26 has been

¹⁰ The Financial Accounting Standards Board, Statements of Financial Accounting Standards No. 76 (Nov. 1983) ("FASB 76"), the other GAAP promulgation directly applicable herein,

the "law" for accountants since its adoption in 1972. J.A. 21, 74-75. It predates PRM § 233 by approximately eleven years. The three dissenting views of the eighteen members of the APB are entitled to no weight for financial accounting purposes. J.A. 23.

APB 26 explains the rationale for current recognition of a loss on advance refunding as follows:

The change in the market value of the debt is caused by a change in the market rate of interest, but the change has not been reflected in the accounts. Therefore, the entire difference is recorded when the specific contract is terminated because it relates to the past periods when the contract was in effect. * * * Furthermore, a call premium necessary to eliminate an old contract and an unamortized discount or premium relate to the old contract and cannot be a source of benefits from a new debt issue. * * * When such debt originally issued at par is refunded, few accountants maintain that some portion of past interest should be capitalized and written off over the remaining life of the old debt or over the life of the new debt.

J.A. 65-66. In other words, because the loss relates entirely to the past term of the refunded bonds, it must be

clarifies when debt is considered "extinguished" for the purposes of APB 26. FASB 76 indicates that such an extinguishment occurs where, as here, "[t]he debtor is legally released from being the primary obligor under the debt either judicially or by the creditor and it is probable that the debtor will not be required to make future payments with respect to that debt under any guarantees." Admin. Rec. at 625-26. There is no dispute in this case that Respondent's obligation under the refunded bonds was extinguished upon the advance refunding transaction. J.A. 9-11.

recognized at the time of the advance refunding when the refunded bond contracts are terminated. Pet. App. 71a.¹¹

42 C.F.R. § 413.24

The next Medicare reimbursement regulation which the court of appeals relied on in rejecting PRM § 233 is 42 C.F.R. § 413.24. This regulation expressly provides that Medicare cost data "must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(b)(2) states: "Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period of which they are incurred, regardless of when they are paid." Under the accrual basis of accounting, advance refunding losses are "incurred" in the year of the refinancing.

Petitioner's suggestion that GAAP embodies a "particular version" of accrual accounting is without any authority. There are no "versions" of accrual accounting.

¹¹ In its opinion, the PRRB equated the treatment of an advance refunding loss as specified in APB 26 with the accounting for a loss on the disposition of a depreciable asset.

This treatment is similar to that which occurs when a fixed asset is disposed of and replaced before the end of its estimated useful life. Any loss on the disposal is clearly related to the old asset and not the replacement. The loss results from the fact that the actual depreciation in value of the asset differs from that recorded on the books. For that reason, the loss on disposal is treated as an allowable cost in the year of disposal. Likewise, the loss on defeasance should be treated as an allowable cost in the year of defeasance.

J.A. 72a; see also PRRB hearing testimony of Mr. Huelskamp and Mr. Langenfeld. J.A. 16-18.

Pet. Bf. 23. The treatise cited by the Petitioner in support of her argument clearly states that "Governments commonly use three bases of accounting: cash, accrual, and modified accrual." M. Dittenhofer, *Applying Governmental Accounting Principles* (1990) § 9.01. Modified accrual thus is not a "version" of the accrual basis of accounting, but a separate basis of accounting. Another treatise upon which Petitioner relies explains the modified accrual basis of accounting as follows:

The modified accrual basis of accounting reflects the concept that a governmental fund is a means of providing accountability and is not concerned with the determination of net income, but only with the measurement of increases or decreases in available, spendable financial resources.

R. Kay & D. Searfoss, *Handbook of Accounting and Auditing*, p. 31-25 (2d ed 1989). Thus, the definition of modified accrual accounting is at odds with the definition of accrual accounting as adopted by section 413.24, which is concerned with recognizing financial transactions in the period when they occur regardless of the timing of cash flow. M. Dittenhofer, *Applying Governmental Accounting Principles* § 9.03.

The accrual basis of accounting, rather than the cash basis or modified accrual basis, is the standardized basis of revenue and cost reporting adopted by GAAP and by Petitioner's cost reimbursement regulations. Petitioner's argument that accrual accounting is not synonymous with GAAP is without merit. "Generally accepted accounting principles encompass the conventions, rules, and procedures necessary to define accepted accounting practice at a particular time." APB Statement No. 4, ¶ 138 (1970). The pervasive principles of GAAP "specify the general approach accountants take to recognition and

measurement of events that affect the financial position and results of operations of enterprises." *Id.* at ¶ 143. "The pervasive measurement principles [of GAAP] establish the basis for implementing accrual accounting." *Id.* at ¶ 144. Section 413.24 requires that hospitals report costs and expenses in the year incurred. Standardized accounting principles, including those set forth in APB 26, require that advance refunding losses be reported as incurred in the year of the defeasance of the refunded debt.

It is irrational for Petitioner to suggest that "financial accounting" principles do not apply to reporting costs for Medicare reimbursement purposes. Pet. Bf. 23. The authorities cited by the Petitioner explain that:

The primary objective of financial accounting is to provide individuals and groups external to management with financial and related information about the current status of the entity and the results of operations. * * * [T]hese outside users will include * * * a variety of **government agencies**. (emphasis added).

D. Keller, J. Bulloch and R. Shultis, *Management Accountants' Handbook*, p. 1.1 (4th ed. 1992). The Medicare cost reimbursement regulations, 42 C.F.R. §§ 413.20 and 413.24, have plainly adopted financial accounting as the basis for cost finding and reporting.

The financial accounting principle of conservatism has no application to advance refunding transactions. APB 26 applies to both losses and gains. Thus, in a gain transaction, the entire gain will be reported in the year of the refunding transaction, contrary to the conservatism principle of understating net income. More important, the principle of conservatism, as explained below, applies

only to the measurement of gain or loss in the context of uncertainty.

Frequently, assets and liabilities are measured in a context of significant uncertainties. Historically, managers, investors, and accountants have generally preferred that possible errors in measurement be in the direction of understatement rather than overstatement of net income and net assets. This has led to the convention of conservatism, which is expressed in rules adopted by the profession as a whole such as the rules that inventory should be measured at the lower of cost and market and that accrued net losses should be recognized on firm purchase commitments for goods for inventory. These rules may result in stating net income and net assets at an amount lower than would otherwise result from applying the pervasive measurement principles.

APB Statement No. 4, ¶ 171 (1970).

On the other hand, the loss or gain incurred in an advance refunding transaction involves no uncertainties. Petitioner recognizes that the amount of the loss or gain is the difference between the net carrying amount of the refunded debt and the amount Respondent was required to pay to the escrow trustee to defease the debt. Pet. Bf. 8 n.5. There is no dispute as to this amount. J.A. 26. When the advance refunding transaction is reported in the year of the refunding, there are no uncertainties as to the amount of gain or loss. Thus, there is no need to apply the accounting principle of conservatism.

The accounting measurement before this Court in *Thor Power Tool Co. v. Commissioner*, 439 U.S. 522 (1979) was quite different than the measurement of gain or loss in an advance refunding transaction. *Thor Power Tool Co.* involved the income tax treatment of a loss resulting from

the write down of excess inventory. In the inventory write down at issue in *Thor Power Tool Co.*, unlike in the case of an advance refunding, there is no external transaction, such as a purchase or sale of inventory, that definitely establishes the value of inventory on hand. The conservatism principle at work in the write down of inventories has no application in the accounting treatment of executed financial transactions such as advance refundings.

In addition, the governing income tax regulations at issue in *Thor Power Tool Co.* differ significantly from the governing Medicare cost reimbursement principles at issue in this appeal. The PRRB's decision in this case carefully explains this distinction as follows:

One of the governing regulations in *Thor* had provided that "[a] method of accounting which reflects the consistent application of generally accepted accounting principles . . . will ordinarily be regarded as clearly reflecting income." Emphasis added. This same regulation also provided that "no method of accounting is acceptable unless, in the opinion of the Commissioner, it clearly reflects income." Emphasis added. Yet another governing regulation provided that an inventory taken in conformity with best accounting practice "can, as a general rule, be regarded as clearly reflecting . . . income." Emphasis added.

* * *

In contrast to the tax code, the Medicare regulations, principally 42 C.F.R. 405.406, [413.20] do not appear to provide authority for the Administrator to reject the use of GAAP to determine actual cost.

* * *

In addition 42 C.F.R. 405.453 [413.24] provides that "The cost data submitted must be based on the accrual basis of accounting which is recognized as the *most accurate basis for determining costs.*" Emphasis added.

This language is much stronger than that in *Thor* which, as indicated above, merely provided in part that the consistent application of GAAP would *ordinarily* be regarded as clearly reflecting income unless the Commissioner decided otherwise. Moreover, the Medicare regulations in question do not appear to provide the kind of authority for the Administrator to reject the use of GAAP to determine actual cost that the Supreme Court found in *Thor*. In fact, they appear to go beyond *Thor* in providing not merely a presumption but an actual requirement that determination of costs conform to generally accepted accounting principles.

Pet. App. 73a-76a. See also *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602. Thus, the plain language of the Medicare cost reimbursement regulations do not give Petitioner the broad discretion to set aside standard accounting principles as did the plain language of the income tax code regulations at issue in *Thor Power Tool Co.*

Petitioner's reference to the Government Accounting Standards Board ("GASB") and Government Accounting Standard No. 23 likewise is not relevant to the issues before the Court. Government Accounting Standard No. 23 by its express terms applies only to government institutions that use proprietary fund accounting.¹² GASB 23

¹² Even if GASB 23 was applicable to nongovernmental institutions, GASB 23 does not become effective until periods

at 23.03. It is undisputed in this case (1) that Respondent is not a governmental institution; (2) that the debt service costs of Respondent, not the debt service costs of City of Cambridge, are at issue in this case; and (3) that Respondent's loss on the advance refunding is an allowable Medicare cost. As a private, nongovernmental institution, Respondent is governed by the accrual accounting principles of GAAP and section 413.24, rather than the accounting principles of GASB.

42 C.F.R. § 413.5

The final reimbursement regulation directly applicable to this case is 42 C.F.R. § 413.5. This regulation appears in Subpart A of Part 413 which refers to "Introduction and General Rules." Section 413.5 itself refers to "Cost reimbursement: General." Section 413.5 is not discussed in Petitioner's brief even though the court of appeals quoted the same at length in its opinion. Pet. App. 7a.

Section 413.5 requires "current" payment of reimbursable costs. The regulation first indicates that "[i]n formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period * * * ." 42 C.F.R. § 413.5(a) (emphasis added). The regulation also provides that one of the "goals" of the "principles of reimbursement" is that "the methods of

beginning after June 15, 1994. *Accounting and Financial Reporting for Refunding of Debt Reported by Proprietary Activities*, Statement of Government Accounting Standards No. 23 (Gov't Accounting Standards Bd. 1993) ("GASB 23") at 23.07.

reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement." 42 C.F.R. § 413.5(b)(1) (emphasis added).

The Contrary Reimbursement Treatment Set Forth in PRM § 233

PRM § 233, unlike the treatment mandated in 42 C.F.R. §§ 413.20, 413.24 and 413.5, continues to tie Medicare reimbursement to the refunded bonds after the advance refunding occurs. Instead of accounting for the loss on advance refinancing currently in the year of refinancing, § 233 "recognize[s] any gain or loss incurred as the result of an advance refunding over the period from the date the refunding debt is issued to the date the holders of the refunded debt receive the principal payment, rather than immediately." Pet. App. 87a. PRM § 233 therefore defies the above regulatory requirements that payment be made according to GAAP and currently in the year when Respondent incurred its advance refunding loss.

The court of appeals below struck down section 233's amortized treatment of an advance refunding loss as inconsistent with 42 C.F.R. §§ 413.20, 413.24 and 413.5. After a very detailed analysis of the plain regulatory language, the court of appeals concluded that section 233 "ignores the structure of the regulations" and "[i]nsofar as the manual provision may represent an interpretation of the regulations, it is neither reasonable nor persuasive * * * ." Pet. App. 11a-12a.

The other federal courts addressing the PRM's amortization of advance refunding losses have all come to this same conclusion. *Mother Frances Hosp.*, Supp. App. A-10 ("We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities."); *Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017 at 38,789 ("Section 233 also 'amends' §§ 413.20 and 413.24 by adding an exception to the application of generally accepted accounting principles."); *Graham Hosp.*, 832 F. Supp. at 1244 ("This Court agrees with the Sixth Circuit in its assessment that 42 C.F.R. Part 413 establishes a cost reimbursement policy consistent with GAAP, with which § 233 conflicts. Therefore, § 233 cannot be viewed as an interpretative rule which clarifies that policy."); *Mercy Hosp.*, CCH Medicare & Medicaid Guide ¶ 40,227 at 30,602 ("The Secretary has explicitly promulgated regulations generally applying GAAP. In those circumstances where the Secretary chooses not to apply GAAP, he is free to promulgate regulations providing for another method of accounting and reimbursement. He has not done so for purposes of this case. It is not difficult to discern that § 215.1 [the PRM predecessor to § 233.3] - as a deviation from GAAP - flies in the face of the Secretary's own governing reimbursement regulations."); *Baptist Hosp.*, 767 F. Supp. at 141 ("[W]e hold that the Secretary's interpretation in the instant action may not be

adopted because it conflicts with the regulations requiring that GAAP be followed."); *Ravenswood Hosp.*, 622 F. Supp. at 344.

Petitioner's theories as to why all these court decisions are wrong are unavailing. Petitioner, for example, argues that the regulations only require that GAAP be applied to provider record-keeping and reporting, and that Petitioner is free to pay providers through any reimbursement methods she deems appropriate. Pet. Bf. 26, 27. This theory contravenes both the plain regulatory language and logic. Petitioner's argument blatantly ignores the "nexus" existing in the regulations between cost reporting and reimbursement. As the court of appeals observed:

But the sentence in 42 C.F.R. § 413.20(a) that says standardized reporting practices "are followed" does not exist in a vacuum. The very first sentence of that section of the regulations begins with a reference to "[t]he principles of cost reimbursement." The sentence that comes immediately after the sentence prescribing use of standardized reporting practices says that changes in these standardized practices "will not be required in order to determine costs payable (by HHS) under the principles of reimbursement." The whole purpose of Part 413, as the introduction to that part explains, is to "set () forth regulations governing Medicare payment" for services furnished, on a cost reimbursable basis, by hospitals and similar health care providers.

Pet. App. 11a.

The critical importance of the consistency between Medicare cost reporting and reimbursement to the provider industry has also been well established. The court

of appeals recognized "that the purpose of cost reporting is to enable a hospital's costs to be known so that its reimbursement can be calculated. For that reason, there must be some consistency between the fundamental principles of cost reporting and those principles used for cost reimbursement." Pet. App. 13a (quoting *Fort Worth Osteopathic Medical Ctr.*, CCH Medicare & Medicaid Guide ¶ 40,413 at 31,848). Likewise, the *Mercy Hosp.* court asserted as follows regarding the Secretary's argument that GAAP only applies to provider record-keeping:

The Secretary's argument is illogical. The Secretary mandates certain record keeping requirements precisely because the provider is entitled to reimbursement of reasonable costs. To suggest that the Secretary required providers to seek reimbursement under one accounting system while he intended to make payment under another is contrary to the structure of the regulations. (quotation omitted).

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,603. For these reasons, there is no merit to Petitioner's argument that GAAP governs provider record-keeping but not reimbursement of advance refunding losses.

Petitioner's suggestion that the reimbursement of a loss on advance refunding in a single year will result in cross-subsidization by Medicare of non-Medicare patients similarly is groundless and has been soundly rejected by the courts. Pet. Bf. 32.

The Secretary's cross-subsidization argument rests on a faulty premise. The regulations cited by the Secretary relate to reasonableness of claimed costs. There has been no allegation that the Hospital has not properly allocated the

claimed costs between Medicare and non-Medicare patients. The parties have agreed that the costs are reasonable and the only outstanding issue is timing: when should reimbursement be made.

Mercy Hosp., CCH Medicare & Medicaid Guide ¶ 40,227 at 30,600. The parties here, too, agree that Respondent has properly allocated the claimed advance refunding loss between Medicare and non-Medicare patients because the hospital is only claiming \$314,000 of its \$672,581 loss as a reimbursable cost under the Medicare program. Pet. App. 4a.¹³

The PRRB further specifically found that the loss on advance refunding relates solely to patient care in the year of defeasance, and thus gives rise to no cross-subsidizations between periods:

The loss was related to patient care in 1985, the year of defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically

¹³ At note 18 of her brief, Petitioner voices the concern that Respondent could later "withdraw entirely from the program," thereby causing a maldistribution of reimbursement for the advance refunding loss between Medicare and non-Medicare patients. Suffice it to say, that such a withdrawal would be extremely unlikely since Respondent, like other provider hospitals, is committed to Medicare program participation with its continually aging patient base. Moreover, if Respondent's proportion of Medicare patient increases in the future, the Medicare program benefits through current payment instead of amortization.

as losses or gains. Thus, there would have been no loss on the extinguishment of the debt. For that reason, the entire loss on defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Pet. App. 71a.

This undermines Petitioner's theory that the entire Medicare portion of Respondent's advance refunding loss is not an allowable cost in 1985. Pet. Bf. 31, 32. Indeed, there is no dispute in this case as to whether the loss is an allowable cost. The dispute instead centers on whether Petitioner can postpone payment for this reimbursable cost over the remaining life of bond issues to which Respondent is no longer a party. The regulations and GAAP provide a very clear answer to this "timing" question. According to the regulations and GAAP, the loss was "incurred" in 1985 and must be reimbursed currently in that year.¹⁴

¹⁴ This "timing" question at issue here is inapposite to the decisions which Petitioner cites in her Petition and Brief standing for the proposition that GAAP cannot make an otherwise unallowable cost reimbursable. These cases include *Sun Towers, Inc. v. Heckler*, 725 F.2d 315 (5th Cir. 1984), *cert. denied*, 469 U.S. 823 (1984); *Homan & Crimen, Inc. v. Harris*, 626 F.2d 1201 (5th Cir. 1980), *cert. denied*, 450 U.S. 975 (1981); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701 (9th Cir. 1980); *Am. Medical Int'l, Inc. v. Secretary of Health, Educ. and Welfare*, 466 F. Supp. 605 (D.D.C. 1979), *aff'd on other grounds*, 677 F.2d 118 (D.C. Cir. 1981). The Fifth Circuit distinguished *Sun Towers*, and thereby these other decisions as well.

In *Sun Towers*, the issue was *whether* a particular cost was allowable at all. In the case at bar, as it was in the *Guernsey* case, the issue is *when* a cost that was clearly allowable should have been reimbursed. These are

Moreover, PRM § 233 assumes that the refunded bonds remain an obligation of Respondent instead of the trustee. J.A. 24-25. At the PRRB, Mr. Langenfeld addressed this point as follows:

Section 233.3 is tying the recognition of the loss to future periods in treating the Provider as if the refunded debt was still on its books and treating it as if the hospital Provider was still a party to * * * the refunded debt issues. And I'm going to argue [that is] arbitrarily tying that to the activity within an escrow account to which the hospital is not a party and forcing the Provider to continue to amortize unamortized discounts and premiums on the old debt while at the same time the provider has incurred additional debt issue costs on the refunding debt and is amortizing those over the future. It's forcing recognition into the future for something that had happened * * * which the Provider cannot reverse in the current period.

J.A. 22.

Although Respondent has no further expenses or cost reporting related to the refunded bonds, PRM § 233 requires the hospital to report this as a reimbursable expense item in years after the advance refunding. This accounting fiction violates the specific reimbursement requirement contained in section 413.20(a) that the "methods of determining costs payable" will involve use

different questions and we do not believe that *Sun Towers* speaks to the issue of *when* reimbursement is to be made. (emphasis in original).

Supp. App. A-12. *Accord Methodist-Evangelical Hosp.*, CCH Medicare & Medicaid Guide ¶ 42,017 at 38,789 ("[E]ach of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement.").

of the "institution's basi[c] accounts, as usually maintained * * * ." It also requires the Medicare program to reimburse Respondent for expenses the hospital does not otherwise incur in relation to non-Medicare patients in violation of the cross-subsidization principle discussed above. In addition, Petitioner's interpretation ignores that Respondent will already be paying reimbursable debt service for the refunding bonds in years subsequent to the advance refunding.

In addition, Petitioner's argument at footnote 10 of her Brief that PRM § 233 is consistent with sections 413.20 and 413.24 because those regulations were originally promulgated in 1967 before APB 26 was issued in 1972 is misleading and without merit. Standardized accounting practices, as required by section 413.20, are not fixed as of a certain date in time. "[GAAP] encompasses the conventions, rules and procedures necessary to define accepted accounting practice *at a particular time*." APB Statement No. 4, ¶ 138 (1970). Section 413.20 requires that standardized accounting practices "that *are* widely accepted" be followed. (emphasis added). Section 413.20 does not require that only those standardized accounting practices that were widely accepted in 1966 be followed. APB 26 was issued in 1972 and it represents the widely accepted accounting standard for reporting losses on advance refunding transactions under the accrual basis of accounting. PRM § 233, which was issued in May, 1983, departed from the then widely accepted accounting standard for reporting advance refunding losses.

Finally, Petitioner attempts to draw an analogy between amortization of advance refunding losses and depreciation of capital assets. Pet. Bf. 32-34. She refers, for example, to *Research Medical Ctr. v. Schweiker*, 684 F.2d

599, 603 (8th Cir. 1982) where the court upheld a PRM section specifying that construction period "interest expense be capitalized over the useful life of the [hospital's] building (thirty years)." Petitioner ignores, however, that with depreciation and amortization of capital assets, there is an asset on the books of the provider. The cost of using that asset is spread over the periods during which that asset remains on the provider's books. There is no accepted accounting practice that would permit capitalizing and then amortizing an asset that is no longer in the possession of the provider or a liability that is no longer the obligation of the provider. Petitioner's depreciation analogy therefore fails.

**PRM § 233 is a Substantive Rule
Promulgated in Violation of the
APA and Medicare Statute**

The APA mandates specific statutory requirements for agency rulemaking. These familiar requirements include advance public notice of a proposed rulemaking through publication in the Federal Register and a public comment period for all interested persons. 5 U.S.C. § 553(b). The prescribed statutory rulemaking procedures serve vital public interests.

Parties affected by the proposed legislative rule are the obvious beneficiaries of proper procedures. Prior notice and an opportunity to comment permit them to voice their objections before the agency takes final action. Congress enacted § 553 in part to "afford adequate safeguards to private interests." Given the lack of supervision over agency decisionmaking that can result from judicial deference and congressional inattention, this protection, as a practical

matter, may constitute an affected party's only defense mechanism. * * *

By the same token, public scrutiny and participation before a legislative rule becomes effective can reduce the risk of factual errors, arbitrary actions, and unforeseen detrimental consequences. * * *

Finally, and most important of all, high-handed agency rulemaking is more than just offensive to our basic notions of democratic government; a failure to seek at least the acquiescence of the governed eliminates a vital ingredient for effective administrative action.

Chamber of Commerce of U.S. v. O.S.H.A., 636 F.2d 464, 470 (D.C. Cir. 1980) (citations omitted).

Under the APA, agencies cannot adopt "substantive" rules without adhering to the rulemaking procedures. A substantive, or "legislative," rule is one "affecting individual rights and obligations. This characteristic is an important touchstone for distinguishing those rules that may be 'binding' or have the 'force of law.'" *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979) (citations omitted). "Interpretative" rules, which may be issued without notice and comment pursuant to the APA, "do not have the force and effect of law" and merely "advise the public of the agency's construction of the statutes and rules which it administers." *Id.* at 302 n.31.

The Medicare statute imposes similar APA requirements of its own for substantive rules. 42 U.S.C. § 1395x(v)(1)(A) requires Petitioner to promulgate as regulations "the methods or methods to be used, and the items to be included, in determining such [reasonable] costs * * * ." 42 U.S.C. § 1395hh(a) likewise provides:

No rule, requirement, or other statement of policy * * * that establishes or changes a substantive

legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subsection shall take effect unless it is promulgated by the Secretary by regulation * * * .¹⁵

Based on the above, it is obvious that PRM § 233 constitutes a substantive rule. The interpretation affects the reimbursement rights of Respondent and has been enforced as a rule of law to deny Respondent current payment for its otherwise reimbursable loss on advance refunding. But for the Secretary's issuance of PRM § 233, Respondent would have received payment for its full Medicare portion of the loss in 1985 according to the existing and properly promulgated regulations. The amortized treatment of an advance refunding loss set forth in the PRM creates a complicated set of new rules that alter the reimbursement regulations calling for the current reimbursement of such a loss when the same was incurred. PRM § 233 makes a substantive change in Petitioner's methods of reimbursement, the items included as reasonable costs, and the scope of benefits and payment for services under the program.¹⁶ As the court of appeals ruled, "§ 233 of the Providers Reimbursement Manual impermissibly changes the meaning of validly adopted

¹⁵ While section 1395hh was enacted after the effective date of section 233, this statute only magnifies the long-standing requirement contained in § 1395x(v)(1)(A) that the Secretary make substantive reimbursement changes by regulation.

¹⁶ For this reason alone, PRM § 233 is a substantive rule regardless of the court of appeals' reading of the plain language of 42 C.F.R. §§ 413.20, 413.24 and 413.5.

regulations." Pet. App. 10a.¹⁷ Since the Secretary elected to issue this substantive rule without public notice and comment according to the APA, PRM § 233 is invalid.¹⁸

The Secretary postulates that PRM § 233 interprets 42 C.F.R. § 413.9 – "Cost related to patient care." Pet. App. 47a. PRM § 233 itself makes no reference to any regulation it purportedly "interprets." Section 413.9, in turn, makes no mention of advance refunding losses or amortizing reasonable costs. This regulation instead merely reiterates that the Medicare program reimburses providers for their "reasonable costs." As Petitioner acknowledges, Respondent's loss on advance refunding is a reasonable cost. Section 413.9(b) does, however, restate the directive in 42 U.S.C. § 1395x(v)(1)(A) that the "[r]easonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." Since Petitioner has refused to promulgate a regulation setting forth her method of reimbursement for an advance

¹⁷ The court in *Methodist-Evangelical Hosp., CCH Medicare & Medicaid Guide* ¶ 42,017 at 38,789, made a similar conclusion based on the four tests for a "substantive" rule recently articulated in *Am. Mining Congress v. Mining Safety & Health Admin.*, 995 F.2d 1106 (D.C. Cir. 1993).

¹⁸ In note 21 of her brief, Petitioner claims certain organizations were consulted prior to the issuance of PRM § 233. Petitioner also admits that section 233 issued without APA notice and comment. Pet. Bf. 36. The fact the Secretary may have discussed the provision with certain external organizations prior to its inclusion in the PRM is irrelevant and outside of the record created before the PRRB. J.A. 3-5. Indeed, the input the Secretary purportedly received on section 233 from these selected groups highlights why formal notice and comment is necessary in this case.

refundng loss, PRM § 233 does not interpret section 413.9, but instead violates this regulation.¹⁹

Finally, Petitioner certainly has the option of seeking to promulgate section 233 as a regulation according to the APA's notice and comment procedures. The Secretary has promulgated by regulation other reimbursement methods which are contrary to GAAP. *See, e.g.*, 42 C.F.R. § 413.134(f)(2) (limitation on recognition of gain or loss on sale of depreciable asset contrary to GAAP approach); 42 C.F.R. § 413.153(b)(2) (provider's investment income offset against otherwise allowable interest expense contrary to GAAP). When the Secretary chooses to depart from the accepted and predictable cost reimbursement methods prescribed by GAAP, she must do so according to APA rulemaking. Because the Secretary has opted not to follow the mandated public notice and comment procedures in issuing PRM § 233, the manual provision is invalid. As the court of appeals aptly concluded: "we do not doubt that the Secretary would have the power to promulgate an actual regulation embodying the substance of § 233. The Secretary's problem, of course, is that she has not done so." Pet. App. 8a, 9a.

¹⁹ Petitioner incorrectly cites the language of 42 C.F.R. § 413.9(b) as applicable to this case. This regulatory provision is not helpful here since it only refers to the annual adjustment of estimated interim Medicare payments with the costs that providers actually incur each year. *See* 42 C.F.R. § 413.60.

CONCLUSION

The decision of the Sixth Circuit is based on the plain language of the applicable Medicare statutes and regulations. The court of appeals' ruling is also consistent with the overwhelming and one-sided federal case law directly on point. For these reasons, the decision of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court, U.S.

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In the Supreme Court of the United States

OCTOBER TERM, 1994

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

DREW S. DAYS, III
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1704

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Financial Accounting Standards Board, Statement of Concepts No. 6 (Dec. 1985)	5
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Provider Reimbursement Manual § 233	4, 5, 8, 9, 11, 12, 13
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In the Supreme Court of the United States

OCTOBER TERM, 1994

No. 93-1251

DONNA E. SHALALA, SECRETARY OF HEALTH
AND HUMAN SERVICES, PETITIONER

v.

GUERNSEY MEMORIAL HOSPITAL

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

1. This Court recently held in *Thomas Jefferson University v. Shalala*, No. 93-120 (June 24, 1994), that the Secretary's interpretation of Medicare provider reimbursement regulations is entitled to substantial deference. The Court explained (slip op. 7-8):

We must give substantial deference to an agency's interpretation of its own regulations. *Martin v. OSHRC*, 499 U.S. 144, 150-51 (1991); *Lyng v. Payne*, 476 U.S. 926, 939 (1986); *Udall v. Tallman*, 380 U.S. 1, 16 (1965). Our task is not to decide which among several competing interpretations best serves the regulatory purpose. Rather, the agency's interpretation must be given "controlling weight unless it is plainly erroneous or inconsistent with the

regulation." *Ibid.* (quoting *Bowles v. Seminole Rock & Sand Co.*, 325 U.S. 410, 414 (1945)). In other words, we must defer to the Secretary's interpretation unless an "alternative reading is compelled by the regulation's plain language or by other indications of the Secretary's intent at the time of the regulation's promulgation." *Gardebring v. Jenkins*, 485 U.S. 415, 430 (1988). This broad deference is all the more warranted when, as here, the regulation concerns "a complex and highly technical regulatory program," in which the identification and classification of relevant "criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy concerns." *Pauley v. BethEnergy Mines, Inc.*, 501 U.S. 680, 697 (1991).

Respondent contends, however, that this deferential standard is inapplicable to this case, on the theory that the Medicare provider reimbursement regulations contain a "clear and unambiguous" (Resp. Br. 17) requirement that generally accepted accounting principles (GAAP) must be followed in all Medicare reimbursement determinations.¹ If the regulations *did* contain a "clear and unambiguous" requirement that GAAP be applied in all reimbursement determinations,

¹ Respondent errs in suggesting (Resp. Br. 19-20) that deference to the Secretary's interpretation of her regulations is unwarranted because a subordinate hearing panel within the Medicare reimbursement system (the PRRB) adopted a contrary interpretation. It is to the Secretary—not to an inferior administrative tribunal whose decisions are reviewed by the Secretary—that deference is due in the interpretation of the Secretary's own regulations. See *Martin v. OSHRC*, 499 U.S. 144, 152-153 (1991); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, 326 (5th Cir.), cert. denied, 469 U.S. 823 (1984).

the Secretary would of course be bound by that requirement. For the reasons explained at length in our opening brief (Pet. Br. 17-35), however, the contention that such an unambiguous requirement exists in the regulations is simply not correct. The regulations do not even mention GAAP, much less mandate the application of generally accepted financial accounting principles in every reimbursement context by "clear and unambiguous" language. Moreover, for the reasons we have previously explained (Pet. Br. 21-23, 30-35), it would be inconsistent with other statutory and regulatory Medicare reimbursement policies for the regulations to be interpreted in that fashion.

a. The more specific of the regulations at issue directs providers to supply the Secretary with "adequate cost data * * * based on * * * the accrual basis of accounting." 42 C.F.R. 413.24(a). This language does not mandate reimbursement in accordance with GAAP. It merely requires providers to keep adequate "financial and statistical records" so that—as the regulation states—such records will be "capable of verification by qualified auditors" of the Secretary. *Ibid.*

To the extent that this regulation has relevance to reimbursement determinations, its "plain language" does not require adherence to GAAP; it requires only that records be maintained and submitted under the "accrual basis of accounting." 42 C.F.R. 413.24(a). The term "accrual basis of accounting" is defined in the regulation to mean the method of accounting under which "revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." 42 C.F.R. 413.24(b)(2). This regulatory description of the "accrual basis of accounting" precisely incorporates the dictionary

definition of that term, which distinguishes "accrual basis" accounting from "cash basis" accounting (under which revenue is reported only when it is actually received and expenses are reported only when they are actually paid). See *Random House Dictionary of the English Language* 13, 322 (2d ed. 1987); *Webster's Third New International Dictionary* 13, 346 (1986); *Kohler's Dictionary for Accountants* 16 (6th ed. 1983); *Black's Law Dictionary* 18-19, 196 (5th ed. 1979). The regulatory reference to "accrual basis of accounting" thus merely directs providers to submit cost information to the agency on the accrual basis, rather than on the cash basis, of accounting.

GAAP is a collection of accounting principles derived from alternative accrual accounting methodologies, but the terms "GAAP" and "accrual basis of accounting" are not synonymous. GAAP represents the consensus of the accounting profession as to which alternative applications of accrual basis accounting methodology are appropriate in specific contexts for financial reporting purposes. D.R. Carmichael, S. Lilien & M. Mellman, *Accountants' Handbook* §§ 1.5(a), 2.4(a), 2.5 (7th ed. 1991). GAAP is thus a subset, not an exhaustive list, of accrual accounting methodologies. By requiring in Section 413.24 of the regulations that providers employ the "accrual basis of accounting," the Secretary rejected cash basis accounting for record-keeping and reporting, but did not thereby abdicate to the accounting profession her discretion to determine which accrual accounting procedure best determines "the reasonable cost of services" (42 C.F.R. 413.9(a)) for Medicare reimbursement purposes in different factual contexts. See Pet. Br. 17-30.

The Secretary's reimbursement policy in Provider's Reimbursement Manual (PRM) § 233 for advance

refunding transactions is, moreover, fully consistent with the "accrual basis" accounting method. Accrual accounting recognizes that amortization is appropriate in some circumstances to properly match benefits to the periods to which those benefits relate. Financial Accounting Standards Board (FASB), Statement of Concepts No. 6, ¶¶ 144-149 (Dec. 1985). In the particular reimbursement context in which this case arises, the Administrator has explained that the lower interest costs resulting from respondent's refinancing "did not relate exclusively to patient care services rendered in the year of the loss" but "more closely related to the years over which the original bond term extended (the period over which the lower interest will be enjoyed)." Pet. App. 49a. See also *id.* at 51a; J.A. 17, 76; Admin. Rec. 312. The policy expressed in PRM § 233 thus represents a particularized application, not an abnegation, of accrual basis accounting.

b. Section 413.20(a) of the regulations likewise does not mandate that Medicare reimbursement determinations always be made in accordance with the generally accepted accounting principles employed for financial reporting purposes. This regulation requires that "[s]tandardized * * * accounting * * * practices * * * in the hospital and related fields" are to be followed in the preparation of data for use by the Secretary in arriving "at equitable and proper payment for services to beneficiaries." 42 C.F.R. 413.20(a). As we explain in our opening brief (Pet. Br. 25-27), this regulation is concerned with the starting point of the reimbursement process—the provision of accurate records by hospitals—and not the ending point of the Secretary's determination of "reasonable costs" for reimbursement purposes.

c. The Foreword to the Provider Reimbursement Manual, which was issued contemporaneously with the regulations, specifies that GAAP is applicable to reimbursement determinations only when no other reimbursement principle or policy in the PRM mandates or calls for a different result. Pet. Br. App. 1a-2a. The Secretary's administrative practice is consistent with that understanding of the regulations. From the initial promulgation of the regulations, the Secretary has consistently adopted the view that the GAAP version of accrual basis accounting is to be applied only when the Medicare reimbursement policies reflected elsewhere in the statute, the regulations or in the guidelines and policies articulated in the PRM do not require a different reimbursement rule. See *ibid.*; 41 Fed. Reg. 46,292 (1976).²

Respondent errs in relying (Resp. Br. 21) on *HCA Health Services Of Mid-West, Inc. v. Bowen*, 869 F.2d 1179, 1180 (9th Cir. 1989), for the proposition that the Secretary once advocated an inconsistent position. In *Bowen*, the court of appeals erroneously described the position of the Secretary as being that GAAP applies to reimbursement determinations "in the absence of any promulgated regulations" to the contrary. *Id.* at 1181. In fact, however, the Secretary's position in *Bowen* was that generally accepted accounting principles are applied in determining reasonable costs for Medicare purposes only when "neither the Medicare statute, the Medicare

² Other indications from the legislative history of the Medicare Act are also consistent with the view that GAAP does not control hospital reimbursement and that its relevance, if any, is simply to provide "an orderly procedure of reporting" costs by hospitals. Resp. Br. 24 n.8, quoting American Hospital Ass'n, *Principles of Payment For Hospital Care* 6, 7 (rev. Aug. 1963). See Pet. Br. 20-21 & n.11.

regulations, nor the Secretary's guidelines specifically address the allowability of" a particular cost (Appellee's Brief at 14, *HCA Health Systems of Mid-West, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1988) (No. 88-5601). The position of the Secretary in his brief in *Bowen* was consistent with (and cited, at 15) the Foreword to the PRM, which states that, "[f]or any cost situation that is not covered by the [PRM's] guidelines and policies, generally accepted accounting principles should be applied." Pet. Br. App. 2a.

The Secretary has not disputed that GAAP provides standard accounting rules that are useful in determining proper Medicare reimbursement when the regulations and the PRM do not otherwise call for a different approach. See Pet. Br. App. 1a-2a. The Secretary, however, has plainly *not* taken the position that her regulations require application of GAAP for reimbursement purposes when Medicare reimbursement policies depart from GAAP financial-reporting principles in particular situations. See Pet. Br. 30-35.³

³ *Amici* American Hospital Association, et al. (AHA) contend that the Secretary has sometimes insisted that GAAP is an inflexible reimbursement requirement. The instances cited by amici, however, primarily concern decisions by the PRRB (AHA Br. 14-15 & n.10), whose view on this issue has been rejected by the Secretary. See Pet. App. 11a-14a; note 1, *supra*. The other administrative decisions principally cited by amici involved (i) affirmance of a PRRB decision on its facts (*Brotman Memorial Hosp. v. Blue Cross/Blue Shield*, [Oct. 1980 - July 1981 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 30,922, at 9839 (Dec. 8, 1980)), and (ii) the question whether the provider had incurred a cost that could be "recorded as such in the provider's financial statements" (*Biscayne Medical Center v. Blue Cross/Blue Shield*, [Oct. 1982 - April 1983 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 32,304, at 9499 (Nov. 5, 1982)). In neither

d. In sum, neither the "plain language" of the regulations, the Secretary's practice under the regulations, nor any "other indications of the Secretary's intent at the time of [their] promulgation" (*Thomas Jefferson University v. Shalala*, slip op. 7-8) requires the conclusion that the agency *must* follow GAAP in all reimbursement determinations under the Medicare Act. Under this Court's consistent decisions, the Secretary's choice "among * * * competing interpretations" of her regulations is therefore entitled to "controlling weight" (*id.* at 7). See also *Udall v. Tallman*, 380 U.S. 1, 16 (1965); *Unemployment Compensation Commission v. Aragon*, 329 U.S. 143, 153-154 (1946).

Moreover, as we explain in our opening brief (Pet. Br. 21-23), the ultimate objectives of financial reporting and Medicare reimbursement determinations are markedly different. The Secretary's conclusion that the accounting principles adopted as GAAP for financial reporting purposes are not binding in determining the "reasonable cost of [Medicare] services" (42 C.F.R. 413.9(a)) is thus "not only a plausible interpretation of the regulation; it is the most sensible interpretation the language will bear" (*Thomas Jefferson University v. Shalala*, slip op. 9).

2. The implementation of the reimbursement regulations contained in PRM § 233 is not a substantive rule. It is an elaboration of the reimbursement standards set forth in the existing regulations.

The Secretary has statutory authority to provide, by regulation, for the reimbursement of the "reasonable

of those decisions did the Secretary take the position that GAAP is binding for all reimbursement determinations.

cost" of provider services. 42 U.S.C. 1395x(v)(1)(A).⁴ She has invoked that authority by promulgating regulations that provide for reimbursement of "the reasonable cost of services * * * related to the care of [Medicare] beneficiaries" and, in particular, of capital-related provider costs that are "appropriate and helpful in * * * maintaining the operation of patient care facilities." 42 C.F.R. 413.9(a) and (b)(2). Reimbursable capital costs include "[n]ecessary and proper interest" and other costs associated with the issuance of capital indebtedness, such as the costs involved in this case. See 42 C.F.R. 413.130(a)(7) and (g); 42 C.F.R. 413.153; Pet. Br. 7.⁵

⁴ Although respondent quotes extensively from 42 U.S.C. 1395hh(a) (see Resp. Br. 2, 46-47), respondent ultimately concedes that the rulemaking requirements of that statutory provision were enacted after PRM § 233 was issued and have no application to this case. Resp. Br. 17 n.15. See Pub. L. No. 100-203, § 4035(a)(3) and (b)(2), 101 Stat. 1330-77 to 1330-78.

⁵ *Amici* Mother Frances Hospital and Osteopathic Medical Center of Texas contend that Sections 413.130(a)(7) and (g) of the regulations are irrelevant to this case because they were promulgated after PRM § 233 was issued. Mother Frances Br. 16-17, citing 48 Fed. Reg. 39,752, 39,809-39,810 (1983). The cited *Federal Register* notice, however, merely reorganized and clarified the preexisting regulations that had authorized reimbursement of capital-related costs, such as interest and "other costs related to * * * capital expenditures." See 42 C.F.R. 405.402(c), 405.419, 405.435 (1982). *Amici* also take issue with the Secretary's reliance upon regulations governing the reimbursement of interest expenses, claiming that such regulations "say nothing about * * * advance refundings." Mother Frances Br. 17. The capital charges at issue in this case, however, represent an accounting "loss" incurred at a given time to save interest expenses in the future. See Pet. App. 47a-48a. The loss associated with respondent's advance refunding transaction represents a component

The Secretary's regulations further require that, in allocating the "reasonable cost" of a service provided over more than one accounting period, the timing of the reimbursement is to be matched to the timing of the provision of that service to Medicare program beneficiaries. This requirement is reflected in the regulations that require that payments made to a hospital in a particular year reflect "the amount determined * * * to be the *actual cost of services furnished to beneficiaries during the year.*" 42 C.F.R. 413.9(b)(1) (emphasis added). See also 42 C.F.R. 413.9(a), 413.60(b); Pet. Br. 31-32. This requirement implements the statutory prohibition against cross-subsidization, which mandates that Medicare funds not be used to subsidize non-Medicare patient services. 42 U.S.C. 1395x(v)(1)(A). See Pet. App. 49a-50a. As the Administrator explained in this case, the amortization of advance refunding costs over the remaining term of the original debt is appropriate to ensure that the reimbursement permitted in any single year reflects the "actual cost of services" furnished to Medicare beneficiaries in that year (Pet. App. 49a):

By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization, and the provider is likewise assured that it will be adequately reimbursed if Medicare utilization increases.

The Secretary's regulations thus provide authority to reimburse capital-related costs and to match such reimbursement to the periods benefited. As all parties

of interest costs, as a "cost incurred for the use of borrowed funds" (42 C.F.R. 413.153(b)).

agree, however, the regulations do not specify how those general principles apply in the particular context of an advance refunding transaction. PRM § 233 exists to provide guidance in precisely this situation. It thus represents a "statement of policy" (*Lincoln v. Virgil*, 113 S. Ct. 2024, 2034 (1993)), or an "interpretative rule[]," as a "statement[] as to what the administrative officer thinks the statute or regulation means" when applied in particular situations. *Gibson Wine Co. v. Snyder*, 194 F.2d 329, 331 (D.C. Cir. 1952). It is not a "substantive rule," for it does not have the force and effect of law or regulations (Pet. Br. App. 1a; 42 C.F.R. 405.1867) and does not create "new law, rights or duties." *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985).⁶ Instead, PRM § 233 "merely clarif[ies] or explain[s] existing law or regulations." *Seldovia Native Ass'n v. Lujan*, 904 F.2d 1335, 1347 (9th Cir. 1990).

Both courts below agreed with the Secretary that amortization of respondent's "advance refunding" costs "squares with economic reality." Pet. App. 8a, 32a. As the Administrator noted, respondent's "loss is a cost of rendering patient care over several years" and therefore should be amortized "over those periods which benefit from the reduced interest rate" (Pet. App. 49a, 51a). The Administrator explained (*id.* at 51a):

⁶ Respondent errs in claiming that PRM § 233 "makes a substantive change in [the] methods of reimbursement." Resp. Br. 47. Medicare has always required that any significant loss resulting from "advance refunding" transactions be amortized. See *Washoe Medical Ctr. v. Aetna Life & Casualty*, [Oct. 1980 - July 1981 Transfer Binder] Medicare and Medicaid Guide (CCH) ¶ 31,073, at 10,336, 10,338 (P.R.R.B. May 27, 1981).

[T]he Provider was not required by the refinancing to make any immediate out-of-pocket payment to satisfy the refinancing loss. Instead, the loss was absorbed by the greater amount borrowed * * *. Thus, the Provider has not actually experienced an immediate unreimbursed outflow of funds. Reimbursement of the loss over a period of years, therefore, will more accurately allocate the Provider's refinancing costs, and, at the same time, more accurately reflect its current costs.

As a rational interpretation and application of the Medicare statute and regulations, PRM § 233 is entitled to "controlling weight." *Thomas Jefferson University v. Shalala*, slip op. 7.⁷

⁷ Respondent contends (Resp. Br. 36-37) that amortized reimbursement of advance refunding costs departs from the regulatory provision that specifies that "[i]n formulating methods for making fair and equitable reimbursement for services rendered [to] beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period" (42 C.F.R. 413.5). Respondent's contention confuses apples with oranges. In many contexts, costs incurred currently to provide benefits over several periods (*e.g.*, capital costs) are routinely and appropriately amortized to match the period of reimbursement to the period in which services are provided to Medicare beneficiaries. The requirement that "current costs," rather than "costs of a past period," be considered in reimbursement determinations merely requires that inflation (or deflation, if that should occur) be taken into account. It does not prevent application of amortization, or the proper matching of reimbursement to the provision of services, as respondent incorrectly suggests. For example, no one disputes that bond issuance costs incurred currently in the course of issuing new debt are to be amortized and reimbursed over the period of the life of that debt. See Pet. Br. 7; Pet. App. 3a-4a. This case simply concerns whether that same amortization principle also applies to

3. Even apart from the question of the validity of PRM § 233, the order at issue in this case should be sustained. This case concerns the validity of a particular reimbursement order; it is not a facial challenge to the validity of an interpretative rule or statement of policy. The Secretary's rational application of the reimbursement regulations to the facts of this case is supported by substantial evidence. See Pet. Br. 34-35; Pet. App. 8a. The Secretary's conclusion that respondent's "loss" on defeasance relates to more than one accounting period and requires amortization—to properly match reimbursement with varying patient service levels over time—is not arbitrary, capricious, an abuse of discretion, or inconsistent with the agency's regulations. The order requiring amortized reimbursement of respondent's advance refunding costs should be sustained for this reason alone. See Pet. Br. 37.

For the foregoing reasons, as well as those stated in our opening brief, the judgment of the court of appeals should be reversed.

Respectfully submitted.

DREW S. DAYS, III
Solicitor General

JULY 1994

Medicare reimbursement determinations to the accounting "loss" associated with an advance refunding transaction.

BEST AVAILABLE COPY

QUESTIONS PRESENTED

The Secretary of Health and Human Services (hereinafter "Petitioner" or the "Secretary") has presented the following questions for review:

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

Respondent Guernsey Memorial Hospital ("Hospital" or "Respondent") in Brief for the Respondent modifies Petitioner's characterization of the questions presented as follows:

1. Whether general Medicare reimbursement regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite a contrary administrative rule issued by the Secretary of Health and Human Services to govern reimbursement of advance refunding losses.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in delaying full reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

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No. 93-1251

**In the
Supreme Court of the United States**

OCTOBER TERM, 1993

DONNA E. SHALALA, Secretary of Health
and Human Services,
Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,
Respondent.

**ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE
SIXTH CIRCUIT**

**BRIEF AMICI CURIAE OF HOSPITALS
PARTICIPATING IN *ST. JOHN HOSPITAL V. SHALALA*
AND *LOSS ON EXTINGUISHMENT OF DEBT*
GROUP APPEAL IN SUPPORT OF RESPONDENT**

INTEREST OF AMICI CURIAE

Amici curiae consist of the twenty-eight hospitals in the Medicare group appeal pending before the United States Court of Appeals for the Sixth Circuit in *St. John Hospital v. Shalala*, Case No. 93-2334, and fourteen hospitals pending in the Medicare group appeal pending before the Provider Reimbursement Review Board ("PRRB") in *Loss on Extinguishment of Debt Group Appeal*, PRRB Case No. 91-0500G. These hospitals collectively are referred to in this brief amici curiae as the "Group Appeal Hospitals."

The Court's decision in the instant case will be dispositive of the appeals in which The Group Appeal Hospitals are engaged.¹ The Group Appeal Hospitals, which comprise the overwhelming majority of hospitals appealing the issue presented by the instant case, submit this brief amici curiae on behalf of Hospital.²

From a Medicare payment perspective, it is primarily the time value of money that is at stake in the instant case and that is at stake for the Group Appeal Hospitals. The true, broad based significance of the Court's decision in this case is whether the Secretary is required to follow the Secretary's own regulations in determining Medicare payment.

The Secretary specifically has referenced *St. John Hospital* regarding the purported financial significance of the instant case, stating as follows: "The significant amount of money at issue in *St. John* will be irretrievably lost if review is deferred to await the development of a more specific conflict." *Petition for a Writ of Certiorari* at 14, n. 9.³

Although the Secretary claims that money "will be irretrievably lost," at issue is the proper *timing* of payment, not whether Hospital or the Group Appeal Hospitals are *entitled* to payment. Indeed, the Secretary ultimately concedes that

¹ The Group Appeal Hospitals in *St. John Hospital* also filed a brief amici curiae before the Sixth Circuit on behalf of Hospital. This brief amici curiae will not repeat the detailed statement of the case, statement of facts and description of the applicable Medicare reimbursement and accounting background that is set forth in the Brief for Respondent filed concurrently with this brief amici curiae.

² Hospital and the Secretary have consented in writing to the submission of this brief amici curiae.

³ This statement was made in the context of the Secretary's forecast of a conflict between the Fifth and Sixth Circuits, which proved to be inaccurate. Since the Court granted the Petition for a Writ of Certiorari absent a conflict between the Fifth and Sixth Circuits, presumably the Petition for a Writ of Certiorari was granted on this alternative basis. Thus, it seems appropriate that the amount in controversy be put in perspective for the Court.

"[i]n most cases, the amount of the allowable refunding loss is undisputed, and the only issue is whether the loss should be allowed in the year of the refunding transaction or amortized over some longer period." *Petition for a Writ of Certiorari* at 25. Thus, the Medicare program has incurred a cost for which the Medicare program is obligated to pay the Group Appeal Hospitals without regard to the outcome of this litigation. Moreover, because the advance refunding transactions of the Group Appeal Hospitals occurred in the mid to late 1980's, as a result of the passage of time most of the amortized payments under PRM § 233 for which the Medicare program is liable already have been paid.⁴ The average percentage difference in Medicare payment for the Group Appeal Hospitals is approximately 7% when payment is made under GAAP, as compared to payment as required by PRM § 233.⁵ While there is some slight increase in payment under GAAP as opposed to under PRM § 233, the Group Appeal

⁴ The Group Appeal Hospitals have been appealing this issue for upwards of five years. The Group Appeal Hospitals are entitled to payment of statutory interest under 42 U.S.C. § 1395oo(f)(2) should they prevail. The Secretary appealed *St. John Hospital* to the Sixth Circuit and moved to stay while the Secretary was evaluating whether to file a petition for certiorari in the instant case. In that motion, which initially was denied but subsequently was granted when the petition for certiorari was filed, the Secretary expressed no concern over the amount of interest accruing while it sought to delay the ultimate resolution of *St. John Hospital*. On the contrary, the Secretary's brief in support of its motion to stay *St. John Hospital* sought to justify delay of *St. John Hospital* in part on the fact that a statutory interest award would be included in the event the hospitals prevailed. Thus, the Secretary should not now have the right to inflate the amount in controversy by referring to statutory interest. Moreover, the Group Appeal Hospitals respectfully submit that they need not offer an apology that in the event they prevail they are entitled under law to an award of interest.

⁵ This slight increase is explained by the fact that the Secretary imposed reductions in Medicare capital payment subsequent to the years in which *St. John Hospital* underwent advance refunding transactions. By receiving payment under GAAP, *St. John Hospital* received the full amount of payment in the year and at the then applicable rate at which they were entitled to receive payment.

Hospitals achieved a huge savings to the Medicare program in the approximate aggregate amount of \$274,000,000 as a result of the advance refunding of debt.

The Secretary states that "[t]he issue is of continuing importance despite the ongoing transition to PPS reimbursement of capital-related costs." *Petition for a Writ of Certiorari* at 25, n.14. If the Group Appeal Hospitals are illustrative of hospitals appealing this issue, this statement is erroneous. In fact, only one of the Group Appeal Hospitals receives increased particular benefit under the Medicare capital prospective payment system methodology in the event their appeal is successful.⁶ All of the other Group Appeal Hospitals will receive a decreased Medicare payment under the capital prospective payment in the event their appeal is successful.

The continuing importance of this issue, therefore, is whether the Secretary is required to comply with the Medicare reg-

⁶ Medicare payment of capital-related costs for inpatient hospital services for cost reporting periods beginning or after October 1, 1991 is based on a prospective payment system methodology. 42 C.F.R. § 412.1-412.352. Under this methodology, a hospital-specific rate is computed based upon a hospital's capital-related costs during its base year, i.e., the cost reporting period ending on or before December 31, 1990. *Id.* 412.302(b). The hospital-specific rate is compared to a national average referred to as the "federal rate" and described in *Id.* 412.308. If the hospital-specific rate is less than the federal rate, the hospital receives a blended payment consisting of a hospital-specific rate component and the federal rate component over a ten-year transition period, with the hospital-specific rate component decreasing, and the federal rate component increasing, each year. *Id.* 412.340. This methodology is referred to as the "fully prospective" methodology. The Secretary's analysis contemplates this methodology. Thus, the Secretary's analysis assumes that all of the Group Appeal Hospitals underwent an advance refunding transaction during the base year, and that they all are paid under the fully prospective methodology. In fact, however, all but eight of the Group Appeal Hospitals have a hospital-specific rate higher than the federal rate, and all but one of those eight underwent an advance refunding *prior* to the base year. The remainder of the Group Appeal Hospitals are paid under a different methodology, referred to as the "hold harmless" methodology. *Id.* 412.344. Under the hold harmless methodology, only one of the Group Appeal Hospitals gains any payment advantage under this new capital-related cost payment methodology.

ulations the Secretary has promulgated as required by the Medicare Act. The United States Court of Appeals for the Sixth Circuit decided below that the Secretary is required to do so. Hospital demonstrates that no conflict exists among the federal courts, which unanimously support Hospital's position. The Group Appeal Hospitals seek to brief this Court that the decision of the Court of Appeals below also is consistent with well-established precedent, particularly with the line of cases decided by the United States Court of Appeals for the Ninth Circuit.

The Group Appeal Hospitals also seek to demonstrate for this Court that application of GAAP to determine the timing of Medicare payment for loss resulting from early extinguishment of debt through an advance refunding transaction is consistent with fundamental Medicare payment principles.

SUMMARY OF ARGUMENT

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually incurred . . . [which] shall be determined in accordance with regulations" 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied). The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries.

In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court of Appeals below properly held that these regulations require, in the absence of a specific regulation to the contrary, the application of generally accepted accounting principles ("GAAP") in determining payment to Hospital for losses incurred in the early extinguishment of debt through an advance refunding transaction. The Court of Appeals correctly analyzed that the Secretary's payment policy, as set forth in Provider Reimbursement Man-

ual ("PRM") § 233, is not a regulation, and that therefore payment must be governed by the applicable regulations.

Hospital briefs this Court that the decision of the Court of Appeals below is consistent with the unanimous decisions rendered by the federal courts, which include decisions of the United States Court of Appeals for the Fifth Circuit and six district courts. This brief *amici curiae* demonstrates for the Court that the decision of the Court of Appeals below also is fully in accord with judicial precedent, including in particular a line of decisions issued by the United States Court of Appeals for the Ninth Circuit, the leading example of which is *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (9th Cir. 1983). The Secretary erroneously argued below, and argues before this Court, that *Villa View* and its progeny are mistaken, and that these decisions display what the Secretary terms "intra-circuit conflict." Careful review of this line of cases reveals that the Ninth Circuit and district courts situated in the Ninth Circuit properly and consistently have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.

In addition to the Ninth Circuit line of cases, virtually every reported case in which either a hospital or the Secretary urges the application of GAAP turns on whether a Medicare regulation, rather than a provision in the Medicare Provider Reimbursement Manual, governs payment contrary to GAAP. Thus, the decision of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, and accordingly should be affirmed by this Court.

Although the holding of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, the Secretary goes to great lengths to convince this Court that PRM § 233 is "rational." This brief *amici curiae* demonstrates that while the application of GAAP reflects the crucial fact that Hospital has been discharged from the old or "refunded" debt, the Secretary's payment policy as set forth in PRM § 233 ignores this reality. The Medicare Act and the Medicare regulations prohibit the cross-subsidization

of Medicare beneficiaries by persons who are not Medicare beneficiaries, and vice versa. Because PRM § 233 ignores the reality that Hospital has been discharged from the refunded debt, the Secretary's payment policy results in a mismatch of costs and years in which Hospital provides services, and thereby works a statutorily prohibited cross-subsidization. Under the analysis established in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988), the application of GAAP in the instant case accurately reflects the cost of patient care.

ARGUMENT

I. THE WEIGHT OF JUDICIAL AUTHORITY HOLDS THAT THE SECRETARY'S REGULATIONS MANDATE THE APPLICATION OF GAAP IN THE INSTANT CASE

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually incurred . . . [which] shall be determined in accordance with regulations" 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied).⁷ The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries. In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court's interpretation of these regulations is dispositive of the issue presented by the instant case.

⁷ Hospital does not contend, and to rule in favor of Hospital this Court need not hold, that the Medicare Act itself requires the application of GAAP. The use of the very term "incurred" in the Medicare Act, however, cannot be ignored. At a minimum, use of this term strongly suggests that reliance on accounting principles is necessary for the determination of costs.

The Court of Appeals below concluded that the regulation set forth in 42 C.F.R. § 413.20 contains

what appears to be a flat statement that generally accepted accounting principles are followed Were it not for § 233 [of the Provider Reimbursement Manual], any fair minded person reading the regulations in light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Guernsey Memorial Hospital, Pet. App. 6a. *Accord*, *Mother Frances Hospital of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994).⁸

Hospital briefs this Court that in addition to the Fifth and Sixth Circuits, six district courts have determined that the Secretary's own regulations require the application of GAAP in determining payment to hospitals for losses incurred in the early extinguishment of debt through an advance refunding. The Secretary, without addressing these cases in *Brief for the Petitioner*, summarily asserts that "the [Sixth Circuit] erred in discerning any such regulatory requirement." *Brief for the Petitioner* at 35.

This interpretation of these regulations by two Courts of Appeals and six district courts fully is in accord with precedent.⁹

⁸ "We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities." 15 F.3d at 426.

⁹ In contesting this interpretation, the Secretary also asserts that the Secretary's "understanding of the text of the regulations is confirmed by the Secretary's longstanding interpretation and consistent administrative practice." *Brief for the Petitioner* at 28. As demonstrated by the *amici curiae* brief filed on behalf of Respondent by Amici American Hospital Association *et al.*, however, review of applicable precedent reveals that

Notably, the decision of the Court of Appeals below is consistent with a line of decisions issued by the United States Court of Appeals for the Ninth Circuit ("Ninth Circuit") holding that the Secretary must apply GAAP in the absence of a regulation to the contrary (not just a Provider Reimbursement Manual ("PRM") provision), the leading example of which is *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (9th Cir. 1983).

The Secretary argues that *Villa View* and its progeny are mistaken because they somehow misconstrued the Ninth Circuit's earlier decision in *North Clackamas Community Hospital v. Harris*, 664 F.2d 701 (9th Cir. 1980). *Petition for a Writ of Certiorari* at 13-14. Finding questionable support only in a *dictum* in footnote 16 of *North Clackamas*,¹⁰ the Secretary concludes that *North Clackamas* stands for the principle that the Secretary can depart from GAAP through the PRM without the support of a regulation. Therefore, the Secretary concludes that the Ninth Circuit's decisions display "intra-circuit conflict." *Petition for a Writ of Certiorari* at 14.

The Secretary's misplaced reliance on footnote 16 of *North Clackamas* is immediately revealed upon further review of *North Clackamas*. In that case, the plaintiff hospital purchased another hospital and a portion of the purchase price was allocated to going concern value ("GCV"). The issue was whether the hospital was entitled to Medicare reim-

the position of the Secretary is not consistent. While this brief *amici curiae* shows that legal precedent follows a consistent thread, the brief *amici curiae* filed by American Hospital Association *et al.* shows that the Secretary's position fluctuates to achieve the outcome desired to suit specific circumstances. See, e.g., *HCA Health Services of Midwest, Inc.*, n.16, *infra*.

¹⁰ Footnote 16 of *North Clackamas* states in its entirety as follows:

The Secretary normally follows generally accepted accounting practices, 42 C.F.R. § 405-406(a) (1979), but when these practices do not accurately reflect the cost of patient care, as opposed to the cost of running a business, the Secretary reserves the right to prescribe different accounting practices. See 41 Fed. Reg. 46,292 (1976).

bursement for the portion of the purchase price allocated to GCV. 664 F.2d at 703. The threshold issue determined by the Provider Reimbursement Review Board ("Board") below in *North Clackamas* was the proper characterization of GCV. The Board found "that GCV 'was more akin to good will than to any other asset.'" *Id.* at 705. Significantly, the Board made this determination based upon GAAP.¹¹ The Board disallowed Medicare reimbursement for GCV, however, because a specific Medicare regulation, *i.e.*, 42 C.F.R. § 405.429(b)(2), explicitly provided that good will was not a reasonable cost reimbursable by the Medicare program. 664 F.2d 705, n.12. Of course, in the instant case it is undisputed that loss on extinguishment of debt is recognized as a Medicare reimbursable cost. In stark contrast to the instant case in which PRM § 233 is not supported by the Medicare regulations, the Board and the district court in *North Clackamas* relied upon a provision of the PRM which mirrored the provisions of the relevant regulation. *Id.* at 705, n.13. Therefore, *North Clackamas* supports the arguments of Hospital in this case that Medicare payment principles must be defined by Medicare regulations.

In *North Clackamas* the Ninth Circuit affirmed the Board's application of GAAP to characterize GCV, and affirmed the Board's application of the Medicare Regulations to determine that GCV was not a reimbursable cost.¹² Footnote 16,

¹¹ "This determination was in accordance with *standard accounting practices* made applicable by 42 C.F.R. § 405.406(a)(1979)" (redesignated as 42 C.F.R. § 413.20, 51 Fed. Reg. 34,790 (1986)) (Emphasis added). 664 F.2d at 705, n. 11. Thus, and as argued by the Hospital in the instant case, *North Clackamas* implicitly recognized that the Medicare Regulation at 42 C.F.R. § 413.20 requires the application of GAAP.

¹² Confirmation that the decision in *North Clackamas* turned on the application of the Medicare regulations is set forth in the decision of the United States District Court for the Central District of California in *Hollywood Presbyterian Hospital-Olmstead Memorial v. Bowen* (No. CV 87-2595, Sept. 2, 1988, Medicare and Medicaid (CCH) Paragraph 37,479). There, as in the instant case, the Secretary relied on a PRM provision that was unsupported by the Medicare regulations to deny reimbursement for

when read in conjunction with footnote 11 of that case as well as in the context of the holding, is authority for the principle on which this Court should decide the instant case, *i.e.*, that the Secretary is required to follow the Medicare regulations, and that the Medicare regulations mandate the application of GAAP.

The portion of *North Clackamas* footnote 16 stating that "the Secretary reserves the right to prescribe different accounting practices" is a mere *dictum*. It is erroneous for the Secretary to conclude based on this mere dictum that the Secretary need not follow the Secretary's own regulations. On the contrary, the law is clear that the Secretary has the right to prescribe different accounting practices only in the Medicare regulations. The Secretary misinterprets this *dictum* as authority for departing from GAAP in the PRM when there is *no* support for such a departure in a regulation. Certainly the dictum does not state that the Secretary can do so. Rather, the Secretary relies heavily on the reference in footnote 16 to the following Federal Register statement:

[GAAP] are applicable to Medicare cost determinations only when a cost situation is not covered by 42 C.F.R. Part 405 or a [PRM]. It is only in the absence of health insurance policy that GAAP should be followed.

Brief for the Petitioner at 30, n.17.

This statement appeared, however, not in the text of a regulation, but in the *preamble* to the October 20, 1976

an employer's Federal Insurance Contributions Act ("FICA") contribution to accrued but unused vacation time. As is evident by the following statement, that court clearly recognized the distinction between the case before it, in which no regulation supported the PRM, and the *North Clackamas* case, in which the decision was governed by the regulations:

The Secretary points to no specific principle embodied in the statute or regulations that would be contravened by the accrual of FICA taxes according to generally accepted accounting principles. Cf. *North Clackamas* (citation omitted) (amortization of goodwill held not reimbursable because attainment of profits is *unrelated to the delivery of needed health services*)

CCH, p. 18,504 (Emphasis added).

promulgation of an amendment to the Medicare regulations entitled "Limitations on Recognition for Equity Capital Purposes of Amounts Paid in Excess of Fair Market Value for Tangible Assets Acquired Prior to August 1970."¹³ The Secretary's very action of amending the Medicare regulations, rather than seeking to depart from the Medicare regulations through the PRM, belies the point which the Secretary and the District Court seek to make in relying on this preamble language. At most, this language evidences the Secretary's prior naked assertion that the Secretary need not adhere to the Secretary's own regulations.

Thus, the Secretary overlooks the issue, facts and holding in *North Clackamas* and relies on a misinterpretation of a *dictum* in footnote 16 to conclude that subsequent Ninth Circuit cases issued over the succeeding decade were decided in error. On the contrary, the Ninth Circuit and district courts situated in the Ninth Circuit properly have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.¹⁴

¹³ It is obvious that a preamble is not a regulation and does not have the force and effect of a regulation. Upon review of the entire preamble, it is apparent that the Secretary's actions belied the statement relied upon heavily by the Secretary that GAAP is "applicable to Medicare cost determinations only when a cost situation is not covered by [the Medicare regulations] or the Provider Reimbursement Manual." Having made this statement, the Secretary immediately contradicts it: "Because such program policy [in the form of regulations] is now being promulgated on this issue, generally accepted accounting principles are not applicable." 41 Fed. Reg. at 46,292. Moreover, while this statement was part of the Secretary's response to several commenters who argued that the Secretary's regulation regarding goodwill departed from GAAP, the Secretary responded "that the amendment is not contrary to 'generally accepted accounting principles.'" *Id.* Thus, this language is ambiguous and, in any event, does not have the force and effect of a regulation.

¹⁴ For example, in the leading case of *Villa View Community Hospital, Inc. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983) the Ninth Circuit was faced with this issue and clearly explained the statement in footnote 16 in *North Clackamas* that "the Secretary reserves the right to prescribe different accounting practices" as follows:

The Secretary erroneously asserts *Villa View* "mis-cited" *North Clackamas* because footnote 16 of *North Clackamas* did not specify that the Secretary's right to prescribe different accounting practices must be exercised by regulation. *Petition for a Writ of Certiorari* at 13-14. The Secretary overlooks that long before deciding *North Clackamas* or *Villa View*, the Ninth Circuit consistently has recognized that the Secretary must follow the Medicare regulations.¹⁵ In fact, the doctrine articulated in *Villa View* has been applied consistently by the Ninth Circuit in every subsequent case in which the Secretary sought to depart from GAAP other than by regulation.¹⁶ Additionally, the Ninth Circuit consistently

Thus, where the Secretary has not prescribed different accounting practices *by regulation*, the Secretary must apply generally accepted accounting principles.

720 F.2d at 1093, n.18 (Emphasis added).

¹⁵ For example, in March of 1980, nine months prior to issuing the decision in *North Clackamas*, the Ninth Circuit stated in a Medicare case: "It is by now axiomatic that agencies must comply with their own regulations while they remain in effect [citations omitted]." *Memorial, Inc. v. Harris*, 655 F.2d 905, 910, n.14 (9th Cir. 1980). Thus, *Villa View*'s explanation that the Secretary could depart from GAAP only through the regulations was merely stating a matter which had become axiomatic and which clearly did not originate with the *North Clackamas* decision. Although the District Court below accepted the Secretary's argument that *Villa View* misconstrued *North Clackamas*, it is respectfully submitted that the District Court's analysis is inconsistent with the foregoing review of these two decisions. Indeed, the Court of Appeals below itself agrees with the Ninth Circuit that "[a]n agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through changes in interpretation unsupported by the language of the regulation." *Fluor Constructors v. Occupational Safety and Health Review Commission*, 861 F.2d 936, 939 (6th Cir. 1988).

¹⁶ In *Vista Hill Foundation, Inc. v. Heckler*, 767 F.2d 556 (9th Cir. 1985), the Secretary relied on the PRM to deny reimbursement based on educational expenses provided to patients of an acute psychiatric facility. In finding that the PRM provision was invalid in light of the Medicare Act and the Medicare regulations, the Ninth Circuit stated "in view of the regulations she [i.e., the Secretary] has chosen to adopt, the Secretary may not deny reimbursement for the educational services at issue in this

has recognized that the Medicare regulations, when specifically applicable, supersede GAAP.¹⁷ In the instant case the Secretary does not point to any Medicare regulation that supports the application of PRM 233 or otherwise supersedes GAAP. Accordingly, GAAP is determinative.

In addition to the Ninth Circuit line of cases, the Court should take notice that virtually every reported case in which either a hospital or the Secretary urges the application of

case." 767 F.2d at 566. Further, the Ninth Circuit recognized that while the Secretary might choose to "amend her regulations," in the interim "the Secretary has no choice but to follow the rules she has adopted." *Id.* That analysis is entirely applicable to the instant case.

Similarly, the Ninth Circuit made the following statement, which is equally applicable to the instant case, in *National Medical Enterprises v. Bowen*, 851 F.2d 291, 294 (9th Cir. 1988):

Because the Secretary's interpretation of the Medicare Act is, by his own admission, contrary to the Medicare regulations regarding accrual accounting, because he has given no basis grounded in the Medicare Act or its regulations for this divergence, and because the accrual accounting regulation is, notwithstanding the Secretary's argument, applicable to the calculation of return on equity, we affirm the ruling of the district court.

Still another case in which the Ninth Circuit applied this principle is *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989), but in that case "[t]he Secretary refused reimbursement on the ground that under [GAAP] (which the Secretary is mandated to apply where an issue has not been covered by agency regulations, 42 C.F.R. § 405.405) there were no reasonable costs incurred." 869 F.2d at 1180. In holding for the Secretary, the Ninth Circuit noted that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply" GAAP. 869 F.2d at 1181.

¹⁷ See *Vallejo General Hospital v. Bowen*, 851 F.2d 229, 233 (9th Cir. 1988) ("In this case the Secretary's actions are adequately supported by the language and purpose of the regulations, so we need not consider GAAP . . ."), *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542 (9th Cir. 1990) (Holding that stock maintenance costs are not "necessary and proper" within the meaning of 42 C.F.R. § 405.451 although such costs are recognized by GAAP); *National Medical Enterprises, Inc. v. Sullivan* ("[C]hallenge to the validity of a regulation promulgated by the Secretary") (Emphasis added).

GAAP turns on whether a Medicare regulation governs payment contrary to GAAP.¹⁸

The Secretary contends that the Court of Appeals misconstrued the requirement of the Medicare Act that the Secretary, in promulgating regulations under that Act "consider . . . principles generally applied by national organizations,"¹⁹

¹⁸ For cases in which the Medicare regulations requiring the application of GAAP governed, see, e.g., *Lexington County Hospital v. Schweiker*, 740 F.2d 287 (4th Cir. 1984) (Secretary's reimbursement treatment upheld because consistent with GAAP); *McKeesport Hospital v. Heckler*, 612 F.Supp. 279, 284 (W.D. Pa. 1985) ("We believe the Secretary's own regulations requiring accrual basis accounting resolves this almost metaphysical problem [of when a cost is incurred]"); *Medical Society of South Carolina v. Heckler* (D.S.C. February 27, 1984) (Medicare and Medicaid Guide ¶ 33,651) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought); *North Shore Medical Center v. Heckler* (S.D. Fla. July 11, 1985) (Medicare and Medicaid Guide (CCH) ¶ 34,991) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought).

For cases in which Medicare regulations govern over GAAP, see *Palms of Pasadena Hospital v. Sullivan*, 932 F.2d 982, 983 (D.C. Cir. 1991) ("Accrual accounting principles might specify something different, but the Board was concerned with statutory principles implemented by regulations." (Emphasis added)); *Methodist Hospital of Indiana v. U.S.* 626 F.2d 823, 826 (Ct. Cl. 1980) ("The Secretary and his delegate have the discretion to determine that a cost was not reasonable or not actually incurred . . . provided that they do so consistently with existing, general regulatory and statutory requirements." (Emphasis added)).

¹⁹ In fact, the Medicare Act states:

In prescribing the regulations . . . the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations.

42 U.S.C. § 1395x(v)(1)(A). This language has been interpreted as delegating to the Secretary the interpretation of reasonable costs through the promulgation of regulations:

The precise methods to be used in determining how much a provider is to be reimbursed for its services, triggered a great deal of Congressional debate. . . . Congress ultimately chose not to specify

as a basis for determining "that the Act was intended to direct the Secretary to consider the financial accounting principles of 'national organizations,' and specifically GAAP." *Brief for the Petitioner* at 19-21. In so doing, the Secretary completely misconstrues the issue. There is no dispute that the Medicare Act does not require the application of GAAP in every instance.²⁰ The importance of the Medicare Act to this case, however, is the undisputed fact that the Act requires the Secretary to promulgate regulations governing Medicare reimbursement. 42 U.S.C. § 1395x(v)(1)(A). *See, also, Charlotte Memorial Hospital*, 860 F.2d 595 (4th Cir. 1988); *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View*, 720 F.2d 1086. The more critical, indisputable fact is that the Secretary, in promulgating such regulations, affirmatively elected to mandate the application of GAAP. 42 C.F.R. 413.20, .24.²¹

As recognized by the Court of Appeals below, had the Secretary elected to depart from GAAP with respect to reimbursement for loss on extinguishment of debt, the Secretary

any rigid formulae. Rather it established general statutory guidelines under section 1395x(v)(1)(A) and authorized the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the [Act]. . . ." (citation omitted) (emphasis added).

Springdale Convalescent Center v. Mathews, 545 F.2d 943, 951 (5th Cir. 1977).

²⁰ The Secretary apparently confused the district court below regarding this point, however, as evidenced by the following statement of the district court suggesting that the Medicare Act requires the Secretary to consider GAAP: "Given the structure of these regulations, the requirement in the statute that the Secretary 'consider,' but not necessarily follow without deviation, generally accepted accounting principles, . . . this court cannot say that the Secretary's conclusion that GAAPs need not be followed in all cases is an impermissible interpretation." Pet. App. 32a.

²¹ Therefore, the Secretary contends it can disregard the Secretary's regulations requiring the application of GAAP merely because the Secretary had the option in promulgating the regulations not to require the application of GAAP.

could have and should have enacted PRM § 233.3 as a regulation. While the Secretary has enacted regulations departing from GAAP in other aspects of Medicare reimbursement, the Secretary has not done so with respect to the loss at issue in this case.²²

The foregoing analysis demonstrates that this Court should affirm the decision of the Court of Appeals below because it is fully in accord with the weight of judicial authority interpreting the applicable Medicare regulations.

II. APPLICATION OF GAAP ACCURATELY REFLECTS THE COST OF PATIENT CARE, WHILE PRM § 233 RESULTS IN IMPERMISSIBLE MISMATCHING OF COSTS AND THE YEARS IN WHICH SERVICES ARE PROVIDED

Hospital aptly briefs this Court that "[a]lthough Respondent has no further expenses or cost reporting related to the refunded bonds, PRM § 233 requires the hospital to report this as a reimbursable expense item in years after the advance

²² *See, e.g.*, 42 C.F.R. 413.134(f) (loss on disposal of assets); 42 C.F.R. 413.17 (costs to related organizations); 42 C.F.R. 413.102 (compensation of owners); 42 C.F.R. 413.106 (physical therapy and other therapy); 42 C.F.R. 405.482 (reasonable compensation equivalent limits or physician compensation). Each of these regulations specifically authorizes a method of reimbursement that departs from GAAP. Also noteworthy is that on October 9, 1991, the Secretary issued a notice of proposed rulemaking entitled "Clarification of Medicare's Accrual Basis of Accounting Policy." 56 *Fed. Reg.* 50,834. The proposed rule, which to date has not been promulgated in final form, would codify as a regulation the following PRM provisions departing from GAAP without support of a regulation: PRM § 2305 (liquidation of short-term liability); PRM § 2146 (vacation pay); PRM § 2144.9 (all-inclusive days off); PRM §§ 2146.2C and 704.3 (FICA and other payroll taxes); PRM § 2144.8 (sick pay); PRM § 906.4 (compensation of owners); PRM § 704.5 (non-paid workers); and PRM § 2162.7 (deferred compensation). The Secretary certainly could, but has chosen to not, promulgate a regulation codifying PRM § 233.

refunding.”²³ Indeed, the Secretary acknowledges this crucial

²³ The record established before the Provider Reimbursement Review Board below is replete with uncontradicted evidence that Hospital was discharged of the old debt. This fact is evidenced in the Termination of Lease and Supplemental Lease, Release and Discharge of Indenture of Mortgage and Supplemental Indenture of Mortgage and Release of Guaranty, a copy of which is set forth in the *Joint Appendix* at 50–52. The Court’s particular reference is directed to the following statement:

“NOW, THEREFORE, the Issuer, the Lessee [*i.e.*, Hospital] and the Trustee hereby agree, confirm and declare that . . . the Original Indenture and the Supplemental Indenture have been and are satisfied and, by this instrument, release, cancel and discharge the Original Indenture and the Supplemental Indenture.” *Joint Appendix* at 52.

This fact also is evidenced by the uncontradicted testimony of Donald Huelskamp: “That’s correct. Paragraph 3D is where the debtor is legally released from being the primary obligor under the debt; which is the situation that we have incurred in the Guernsey Memorial Hospital situation.” *Joint Appendix* at 17. This fact also is evidenced by the uncontradicted testimony of Douglas E. Langenfield: “In reality in 1985 the hospital relieved itself of any obligation of the 1972 and 1982 bonds . . .” *Joint Appendix* at 17.

Further confirmation of this fact was requested by the Provider Reimbursement Review Board during the hearing below. This confirmation was provided by Hospital’s legal counsel in Exhibit A to *Provider’s Post-Hearing Brief* dated October 10, 1989: “[W]e advise you that the 1972 Bonds and the 1982 Bonds have been deemed paid and discharged within the meaning of the Prior Indenture, and the Hospital has been released and discharged from any further obligation to pay debt service on the 1972 Bonds and the 1982 Bonds.” *Joint Appendix* at 11 (Emphasis supplied).

Testifying on behalf of the fiscal intermediary, Diane Andrews conceded the liability for the old debt was transferred to the trustee of the escrow account into which proceeds of the new debt had been deposited:

Q. Is it a cost incurred by the trustee?

A. The trustee would be making the actual payments.

Q. It was a cost incurred by the trustee in addition to making the payment, it was a cost incurred by the trust?

A. Yes.

fact: “[T]he establishment and funding of the escrow account released respondent from any further obligation to the holders of these bonds.” *Brief for the Petitioner* at 8.

Because Hospital was no longer obligated on, and thus incurs no further loss relating to the old debt, the Medicare Act would prohibit, as an impermissible cross-subsidization, Hospital from being reimbursed for the cost of that debt in years after the advance refunding transaction. 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. § 413.9(b).²⁴ The Secretary also acknowledges the critical importance of this principle: “A central concern of ‘reasonable cost’ reimbursement is that any costs ‘allowed’ under Medicare must be properly matched to services provided to the program’s beneficiaries during the applicable period.” *Brief for the Petitioner* at 31–32.

Thus, the Secretary’s argument that amortization is “reasonable” because it matches the cost of care in the year in which the care is provided is based on the undeniably false premise that Hospital remains liable on the old debt.²⁵ While the Secretary does not, and indeed cannot, deny this fact, the Secretary seeks to justify amortization by making an analogy “to allowable costs that relate to more than one accounting period — such as capital costs from which ben-

²⁴ The prohibition on cross-subsidization requires that Medicare not bear the costs of services to individuals who are not Medicare beneficiaries, and vice versa.

²⁵ The Secretary goes to great lengths to demonstrate to this Court that PRM § 233 is “rational,” based on the statement of the Court of Appeals below that “there is nothing irrational about [PRM § 233].” Pet. App. 8a. This statement is a *dictum* to the holding that the Medicare Act requires the Secretary to promulgate regulations for the determination of reasonable cost. In the words of the Court of Appeals: “The Secretary’s problem, of course, is that she has not done so.” *Id.* 9a. This Court should affirm the decision of the Court of Appeals on the identical basis. Because the Secretary’s principal argument appears to be a justification of PRM § 233, amici amplify Hospital’s analysis by briefing the Court regarding the inherent errors in the Secretary’s contentions. As cited in n. 30, *infra*, the Provider Reimbursement Review Board also found the Secretary’s analysis to be flawed because it ignores that the debt has been defeased.

efits will be derived over several periods" *Brief for the Petitioner* at 32.

The Secretary's justification fails for several reasons. First, the payment at issue in this case is not for a capital cost. Second, the rationale for amortizing capital costs has nothing whatsoever to do with "benefits derived over several periods." Rather, capital costs are amortized to reflect that capital assets are consumed over several cost reporting periods rather than being fully used in one cost reporting period. See 42 C.F.R. §§ 413.134-413.144. In the context of this case in which Hospital no longer has liability under the old debt, applying the Secretary's logic a provider would continue to receive Medicare payment for a capital cost after the provider has disposed of, and long-since has relinquished legal title to, the capital asset.²⁶ Finally, the Secretary also amortizes a gain on advance refunding, when clearly the gain is not a "benefit" to the provider but rather an amount

²⁶ While amortization of capital costs has nothing to do with the "benefit" concept advanced by the Secretary, a more fitting analogy is the disposal of a capital asset. As with an advance refunding transaction, the disposal of a capital asset can result in a gain or loss. In essence, the Medicare program recomputes the useful life of the asset to reflect the early retirement of the asset. This recomputation of the useful life of the asset, depending upon the specific facts, could result either in a payment to the provider to reflect the provider's loss or an adjustment to reflect recapture of depreciation. Consistent with GAAP, these adjustments occur in their entirety in the year in which the capital asset is disposed. See 42 C.F.R. § 413.134 (f). In the case of Medicare payment for loss resulting from disposal, the Secretary generally does not amortize the payment over the remaining life of the disposed asset to reflect the "benefit" to the provider over that period. Similarly, where there is a recapture, which would be analogous to gain on advance refunding, the Secretary does not choose to amortize this detriment to the provider. Where there is an exception to the timing of recognition of gain or loss, it is done so by regulation. For example, an exception to the GAAP approach is made regarding the demolition or abandonment of assets resulting in losses in excess of \$5,000 and which are not 80 percent depreciated. In that instance, the loss is amortized over the remaining useful life of the demolished or abandoned asset. *Id.* § 413.134(f)(5)(iv). Of course, however, this non-GAAP approach is authorized by regulation.

the provider is required to pay to the Medicare program. *Henry County Memorial Hospital v. Shalala*, No. IP 92-1044-C (S.D. Ind. Feb. 23, 1994) Medicare and Medicaid Guide (CCH) ¶ 42,129.

Understood in light of the uncontested facts established before the Provider Reimbursement Review Board below, the application of GAAP, not the application of PRM § 233, accurately reflects the cost of patient care. The decision in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988) is particularly instructive regarding the proper analysis of the instant case.²⁷ As in the instant case, the court was faced with the question of whether GAAP should be applied in the absence of a Medicare regulation to the contrary. The court refrained from reaching the issue of the Secretary's authority to depart from GAAP without regulatory basis: "Even if the Secretary, in the absence of an enabling regulation, is authorized to prescribe a regulatory interpretation [i.e., in the PRM] that conflicts with GAAP, a proposition we do not decide today, the Secretary would be at the very limit of his authority in so doing." 860 F.2d at 600. Instead, the court's analysis was based upon the theory that greater scrutiny is required: "The focus of this scrutiny is whether, with respect to the type of medical cost at issue, the departure from GAAP is supported by a showing that GAAP 'do not accurately reflect the cost of patient care, as opposed to the cost of running a business.'" *Id.* [citing *Villa View*.]²⁸

As in the instant case, in *Charlotte Memorial* the issue was the proper timing of payment of a Medicare cost, the allow-

²⁷ *Charlotte Memorial* was cited by the Court of Appeals below, although its holding that the Medicare regulations require the application of GAAP did not require it to engage in the analysis set forth in that decision. Pet. App. 10a, n.2.

²⁸ See n. 14, *supra* and accompanying text.

ability of which was not in dispute.²⁹ The court found that "GAAP provide the guiding light for determining when, under 42 C.F.R. § 413.24 a hospital incurs a reimbursable debt" *Id.* at 598. The court reasoned that "the GAAP approach . . . captures the tenor of the applicable regulation [*i.e.*, 42 C.F.R. § 413.24]" *Id.* at 599. The court explained that "[t]he core of the GAAP approach . . . is that, during each cost reporting period, cost reimbursements should rationally coincide with the real debt [incurred]." *Id.* at 601.

Accordingly, the court found that regardless of when the doctors received deferred compensation, the hospital incurred liability when it set aside the money to fund the deferred compensation. *Charlotte Memorial* teaches, therefore, that for purposes of determining when a cost is *incurred* under 42 C.F.R. § 413.24, reliance on GAAP is appropriate.³⁰ In the instant case, upon extinguishment of the old debt, Hospital has been legally discharged from the debt, no longer has reimbursable costs related to the old debt and, therefore, cannot subsequently be reimbursed for costs which legally have been transferred.

Application of GAAP, therefore, recognizes the crucial fact that Hospital is discharged from liability under the old

²⁹ The provider claimed reimbursement for funds that it set aside as deferred compensation for executives. The intermediary disallowed reimbursement for the funds set aside because they were not deposited in a plan which complied with the requirements of the PRM. Under the applicable GAAP, however, the set aside funds constituted a recognizable deferred compensation expense.

³⁰ The Provider Reimbursement Review Board below reached the very conclusion that GAAP properly matched costs in the year in which services were provided:

The loss was related to patient care in 1985, the year of the defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. . . . [T]he entire loss or defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Pet. App. 71a.

debt. The Secretary's policy in PRM § 233, however, ignores this reality, and thus violates the statutory prohibition on cross-subsidization.

CONCLUSION

The Judgment of the United States Court of Appeals for the Sixth Circuit should be affirmed.

Respectfully submitted,

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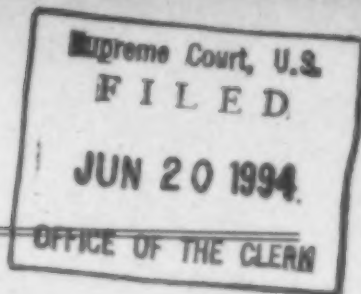
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Extinguishment of Debt Group
Appeal

(8)

No. 93-1251



In The
Supreme Court of the United States
October Term, 1993

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

BRIEF OF AMICI CURIAE
MOTHER FRANCES HOSPITAL AND
OSTEOPATHIC MEDICAL CENTER OF TEXAS
IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

Mother Frances Hospital of Tyler, Texas, and Osteopathic Medical Center of Texas (the "Amici Hospitals") both have a direct interest in the outcome of this case, because both currently have lawsuits pending on the advance refunding issue presented by the case at bar.

Mother Frances Hospital is a not-for-profit, religiously affiliated hospital located in Tyler, Texas. Osteopathic Medical Center of Texas is a not-for-profit hospital located in Fort Worth, Texas.

For its fiscal year ending in 1987, Mother Frances Hospital sought Medicare reimbursement for a loss incurred on an advance refunding transaction similar to the one in the case at bar. The hospital sought to be reimbursed for the loss in the year in which the advance refunding occurred. The hospital prevailed before the Provider Reimbursement Review Board ("PRRB"), but that decision was reversed by the Administrator of the Health Care Financing Administration ("HCFA"). *Mother Frances Hospital (Tyler, Tex.)*, PRRB Dec. 92-D11 (Feb. 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,014; *Mother Frances Hospital*, HCFA Admin. Dec. (Mar. 30, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,778. Mother Frances Hospital sought judicial review of the Administrator's decision, culminating in a decision on March 3, 1994, by the United States Court of Appeals for the Fifth Circuit. *Mother Frances Hospital of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994). Mother Frances Hospital prevailed in the Fifth Circuit. The Fifth Circuit's opinion expressly relied upon the decision of the Sixth Circuit in the *Guernsey* case. *Id.* at 427-28. On May 31, 1994, the governmental defendants in the *Mother Frances* case filed a petition for a writ of certiorari with this Court. *Shalala v. Mother Frances Hospital of Tyler, Texas*, No. 93-1907.

Osteopathic Medical Center of Texas also sustained a loss on advance refunding, and sought to recover Medicare reimbursement for such loss for the year in which the transaction occurred. After the hospital prevailed before the PRRB, the Administrator reversed in the *Osteopathic Medical Center* case as well. *Fort Worth Osteopathic Medical Center* (Fort Worth, Tex.), PRRB Dec. 92-D39 (July 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,413; *Fort Worth Osteopathic Medical Center*, HCFA Admin. Dec. (Sep. 9, 1992), Medicare & Medicaid Guide (CCH) ¶ 40, 870. Osteopathic Medical Center of Texas then brought suit in the Northern District of Texas, seeking reversal of the Administrator's decision. The case is currently pending. *Fort Worth Osteopathic Hospital, Inc. d/b/a Osteopathic Medical Center of Texas v. Shalala*, Civil Action No. 3:CV-92-2337-P (N.D. Tex.). The Sixth Circuit in the *Guerney* case relied in part upon the reasoning of the PRRB's decision in the *Osteopathic Medical Center* case. Pet. App. 12a-13a.

The issues presented by this case have been presented in the *Mother Frances* and *Osteopathic Medical Center* cases. Accordingly, both hospitals have a direct stake in the outcome of this litigation and, in accordance with the letters of consent of both parties being filed herewith, respectfully submit this Brief of Amici Curiae.

SUMMARY OF ARGUMENT

The Amici Hospitals will not address whether 42 C.F.R. §§ 413.20(a) and 413.24 require Medicare reimbursement in this case to be determined in accordance with generally accepted accounting principles ("GAAP"). Instead, this brief addresses issues under the Administrative Procedure Act ("APA") concerning whether PRM § 233 is a "substantive" rule, "interpretative" rule, or "general statement of policy" under the APA, and

whether the Administrator's decision is in accordance with APA standards for review of agency decisions.

Under the APA and prevailing case law, PRM § 233 is a "substantive" rule. It creates the law relating to losses on advance refunding, specifies the obligations of hospitals in detail, and has been enforced by the Secretary in a binding manner. Furthermore, PRM § 233 changes the reimbursement rules previously applied by the Secretary to losses on advance refundings. It is a change from PRM §§ 215 and 215.1, which preceded PRM § 233. It also is a change from a rule of decision that looked to GAAP requirements which was applied by the Secretary to advance refundings prior to the existence of any Medicare manual provisions on this subject. Certainly, it represents a change from the GAAP requirement imposed by 42 C.F.R. §§ 413.20(a) and 413.24, but even if those regulations did not exist, PRM § 233 is a change from the rules previously applied in fact by the Secretary.

PRM § 233 is not an "interpretative" rule, as the Secretary contends. There is no regulation that addresses advance refundings or cognate issues. The only regulation quoted by the Administrator in his decision, of which he claimed PRM § 233 to be interpretative, is 42 C.F.R. § 413.9(b)(1). That regulation, however, only addresses retroactive adjustments, a subject unrelated to PRM § 233. The other four regulations now cited by the Secretary in her brief were not relied upon by the Administrator in his decision, were not argued before the Sixth Circuit, and do not provide any support for PRM § 233.

Similarly, the Secretary's contention that PRM § 233 is a "general statement of policy" is erroneous. PRM § 233 has been applied in a binding fashion by the Secretary, and cannot be considered as a statement of the agency's

"tentative intentions for the future." If, *arguendo*, PRM § 233 were to be considered a general statement of policy, it could not provide any support for the Administrator's decision. In order to stand, that decision must be supported by the administrative record as if PRM § 233 had never been issued. However, the administrative record in this case does not provide substantial evidence to support the Administrator's decision.

The decision of the Sixth Circuit should therefore be affirmed.

ARGUMENT

The parties in this case have presented two issues for review, although they phrase them somewhat differently.

The first issue is whether the regulations codified at 42 C.F.R. §§ 413.20(a) and 413.24 require Medicare reimbursement for losses on advance refundings to be determined in accordance with GAAP instead of in accordance with PRM § 233, a Medicare manual provision.

The second issue is whether PRM § 233 constitutes a "substantive" or "legislative" rule under the APA, and is thus invalid due to the failure of the Secretary to promulgate it as a regulation by publishing it in the *Federal Register* after notice and an opportunity for public comment.

The Amici Hospitals strongly agree that 42 C.F.R. §§ 413.20(a) and 413.24 require GAAP to be followed in making Medicare reimbursement determinations under the circumstances of this case. However, that issue will not be addressed in this brief.

Instead, this brief will focus on APA issues related to the rulemaking argument, in a broader context than the parties have been able to address. Particularly, the Amici Hospitals will demonstrate that the Secretary's arguments, if accepted, would permit her to evade the APA's rulemaking requirements and its requirements that administrative decisions be based on the record created at the hearing.

I. THE ADMINISTRATOR'S DECISION MUST BE REVERSED BECAUSE IT IS FOUNDED ON PRM § 233, WHICH IS A SUBSTANTIVE RULE PROMULGATED WITHOUT NOTICE AND COMMENT UNDER THE APA

A. The APA requires notice and comment rulemaking for substantive rules such as PRM § 233.

The APA requires notice of proposed rulemaking to be published in the Federal Register, and the notice must contain certain specified information. 5 U.S.C. § 553(b). The agency is required to give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without the opportunity for oral presentation. 5 U.S.C. §§ 553(c), 553(d). After consideration of the relevant matter presented, "the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose." 5 U.S.C. § 553(c). The statement of basis and purpose is meant, among other things, "to facilitate meaningful judicial review. The agency's statement must be sufficiently detailed and informative to permit a reviewing court to determine how and why the rules were actually adopted." 3 J. Stein, G. Mitchell, and B. Mezines, *Administrative Law* § 15.09, at 15-164, 15-165 (rev. ed. 1994).

A narrow exception to the notice and comment requirement exists for "interpretative" rules. 5 U.S.C.

§ 553(b)(A). "Interpretative" rules, as opposed to "legislative" or "substantive" rules, are those "which merely clarify or explain existing law or regulations," *Alcaraz v. Block*, 746 F.2d 593, 613 (9th Cir. 1984), quoting *Powderly v. Schweiker*, 704 F.2d 1092, 1098 (9th Cir. 1983). "An agency rule that reminds parties of existing statutory duties is also considered interpretative, not legislative." *National Family Planning and Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 236 (D.C. Cir. 1992). The exception for interpretative rules to the APA's notice and comment rulemaking requirements is "narrowly construed and only reluctantly countenanced." *Alcaraz*, 746 F.2d at 612, quoting *American Federation of Government Employees v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981).

The Secretary agrees that a rule is "substantive" if it "impose[es] a new substantive obligation." Pet. Br. at 38 n.23, citing *McCown v. Secretary of HHS*, 796 F.2d 151, 157 (6th Cir. 1986), cert. denied, 479 U.S. 1037 (1987). Another test cited by the Secretary is that a rule is "substantive" if it creates "new law, rights, or duties." *Id.*, citing *Friedrich v. Secretary of HHS*, 894 F.2d 829, 834 (6th Cir.), cert. denied, 498 U.S. 817 (1990) (quoting *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 D.C. Cir. 1984) (en banc), cert. denied, 471 U.S. 1074 (1985)). Many courts of appeals have defined substantive rules as those which "grant rights, impose obligations, or produce other significant effects on private interests."¹ Substantive rules have also been characterized as "those which effect a change in

¹ See, e.g., *National Family Planning and Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 238 (D.C. Cir. 1992); *Perales v. Sullivan*, 948 F.2d 1348, 1354 (2d Cir. 1991); *American Ambulance Service v. Sullivan*, 911 F.2d 901, 907 (3d Cir. 1990); *Avoyelles Sportsmen's League, Inc. v. Marsh*, 715 F.2d 897, 908 (5th Cir. 1983); *Ohio Dep't of Human Services v. United States Dep't of Health and Human Services*, 862 F.2d 1228, 1233 (6th Cir. 1988); *Zaharakis v. Heckler*, 744 F.2d 711, 713 (9th Cir. 1984).

existing law or policy,' or remove previously existing rights." *Linoz v. Heckler*, 800 F.2d 871, 877 (9th Cir. 1986) quoting *Powderly*, 704 F.2d at 1098.²

B. PRM § 233 is a substantive rule.

Under the tests stated above, PRM § 233 is a substantive rule that was not promulgated through rulemaking, and is therefore invalid.

First, PRM § 233 "creates new law, rights or duties," and "grant[s] rights, impose[s] obligations, or produce[s] other significant effects on private interests."

Instead of being interpretative of a regulation, PRM § 233 creates out of whole cloth a detailed set of payment rules governing advance refundings. If one examined only the Medicare statutes and regulations, one would have not the slightest clue as to how payment for advance refundings would be treated (unless GAAP were followed pursuant to 42 C.F.R. § 413.20(a)). PRM § 233 does

² Apart from the APA, there is also a specific Medicare statute that specifies when the Secretary must proceed by rulemaking. The statute provides that "No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . under this subchapter shall take effect unless it is promulgated by the Secretary by regulation" 42 U.S.C. § 1395hh(a)(2). Although this specific language was added to the statute after the effective date of PRM § 233, it is instructive that Congress has now also manifested its understanding that provisions such as PRM § 233 that "establish or change" a "substantive legal standard" governing "the payment for services" are the types of substantive rules that are ineffective unless they are promulgated by regulation, as the case law and APA already provided.

not "elaborate on what is already contained in the regulations," as the Secretary contends. Pet. Br. at 40. Instead, it is being used as a substitute for or supplement to the regulations and statutes. As a recent D.C. Circuit case stated: "[A] rule is legislative if it attempts 'to supplement [a statute], not simply to construe it.'" *National Family Planning*, 979 F.2d at 237 (quoting *Chamber of Commerce v. OSHA*, 636 F.2d 464, 469 (D.C. Cir. 1980)). PRM § 233 creates "new law" regarding advance refundings. PRM § 233 imposes on providers an "obligation" or a "duty" to defer receipt of Medicare reimbursement into future years. That obligation is not discernable or even hinted at anywhere in the Medicare regulations. Unquestionably, PRM § 233 also "establishes" a "substantive legal standard" governing "the payment for services." 42 U.S.C. § 1395hh(a)(2). Under PRM § 233, the standard for payment is set forth explicitly, and that standard requires payment to be amortized over future periods.³

Second, PRM § 233 "effect[s] a change in existing law or policy" governing reimbursement for advance refunding losses, *Linoz*, 800 F.2d at 877, and "changes a substantive legal standard" governing "payment for services." 42 U.S.C. § 1395hh(a)(2).

HCFA originally had no written rule or manual provision expressly governing treatment of losses on advance refundings. Instead HCFA followed GAAP in

³ Although the Secretary characterizes PRM § 233 as not having "the force and effect of law" as do substantive rules, Pet. Br. at 37, and refers to it as only an "informal guideline," *id.*, it has been applied by the Secretary as a binding rule. See Part III, below.

determining how losses from refunding transactions should be reimbursed. In *Washoe Medical Center*, PRRB Dec. 81-D51 (May 27, 1981), Medicare & Medicaid Guide (CCH) ¶ 31,074, the advance refunding had taken place in 1972, prior to the effective date of APB No. 26. As permitted under GAAP in 1972, the provider elected to amortize the loss. After the effective date of APB No. 26, the provider attempted to take the balance of the loss in a single year, as APB No. 26 prescribed. HCFA refused to allow the provider to do so, on grounds that GAAP must be followed and that the loss had occurred prior to the effective date of APB No. 26. The decision of the PRRB states:

The Board finds that the balance of the unamortized loss claimed by the provider on the advance refunding of its bonds is not allowable in 1978. The provider's amortization of this loss was an acceptable method of reporting the loss under generally accepted accounting principles in effect during 1972, the year of the advance refunding, and under section 212.1 of the PRM. *The APB Opinion No. 26*, as amended (APB No. 26) cited by the provider as authority to write off the unamortized loss in 1978 is effective for all extinguishments of debt occurring on or after January 1, 1973. Since the provider's loss on advance refunding occurred during fiscal year ending June 30, 1972, that Opinion is not applicable. (emphasis added)

Id., ¶ 31,074 at 10,338. It is clear from this passage that the PRRB looked to GAAP as providing the binding rule of decision for treatment of a loss on advance refunding. The *Washoe* decision was not reversed or modified by the Administrator, and so is final, official action by the Secretary.

Next, HCFA issued PRM §§ 215 and 215.1. Medicare & Medicaid Guide (CCH) ¶¶ 5007, 5008. In a series of decisions later reversed by the courts, the Administrator interpreted PRM §§ 215 and 215.1 to apply to advance refundings. See *Baptist Hospital East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hospital v. Sullivan*, No. 90-0024-P (D.Me. 1991), Medicare & Medicaid Guide (CCH) ¶ 40,227; *Ravenswood Hospital Medical Center v. Schweiker*, 622 F. Supp. 338 (N.D. Ill. 1985). Amortization of losses over future years was required under §§ 215 and 215.1 only for "big losses" amounting to 50% or more of the cost that would have been incurred during the year. "Small losses," amounting to less than 50% of the cost that would have been incurred in that year, were reimbursed in full in the year in which they were incurred. Unlike losses, PRM §§ 215 and 215.1 required gains on advance refunding to be taken in their entirety in the year in which they were incurred. *Ravenswood*, 622 F.Supp. at 344-45.

PRM § 233, by contrast, does not provide for differential treatment between larger and smaller losses, based on the 50% limit that was provided by PRM §§ 215 and 215.1. PRM § 233 also changed the rule in PRM §§ 215 and 215.1 that required gains to be recognized currently, instead of treating gains in the same manner as losses, as PRM § 233 requires.

As shown above, HCFA has had at least three different substantive policies regarding treatment of losses on advance refunding: 1) following GAAP, as in the *Washoe* case; 2) PRM §§ 215 and 215.1; and 3) PRM § 233. Thus, § 233 does not merely "elaborate on what is already contained in the regulations." Pet. Br. at 40. There is no regulation regarding treatment of losses on advance

refundng. Instead, PRM § 233 is a substantive rule that changes previously existing law or regulations. *Linoz*, 800 F.2d at 877.

C. The rulemaking argument is logically independent of any finding as to whether 42 C.F.R. § 413.20(a) requires GAAP to be followed in this case.

The Secretary argues that the conclusion by the Sixth Circuit that PRM § 233 is a "substantive" rule "has no force independent of the court's determination that the Manual provision, which was issued without formal notice or comment, [footnote omitted] conflicts with what the court perceived to be a GAAP-based reimbursement requirement embodied in Sections 413.20 and 413.24 of the regulations." Pet. Br. at 36. A similar statement appears at page 17 of the Petitioner's Brief.

The Secretary misconceives the nature of the rulemaking argument. The rulemaking argument in this case is logically independent of the argument that the GAAP and accrual accounting regulations require reimbursement for a loss on advance refunding in the year in which the loss is incurred. If, as the Sixth Circuit found, 42 C.F.R. § 413.20 requires GAAP to be followed in determining reimbursement, it is certainly true that PRM § 233 represents a change from the requirement of that binding regulation (indeed, flatly contradicts it) and is thus a substantive rule.

However, it does not follow that PRM § 233 is necessarily "interpretative" and not "substantive" if it were to be found that 42 C.F.R. §§ 413.20 and 413.24 do not require GAAP to be followed. Had those regulations

never existed, PRM § 233 would still “create law” regarding treatment of advanced refundings, and “impose obligations” on providers to defer the loss to future years. Furthermore, as demonstrated above, PRM § 233 represents a change in fact from the previous standards employed by Medicare in determining treatment of a loss on advanced refunding. It represents a change from PRM §§ 215 and 215.1, which in turn represented a change from the GAAP rule applied by the Secretary in the *Washoe* case.

Thus, PRM § 233 meets the definition of a “substantive” rule under the APA and relevant case law, even if it does not conflict with §§ 413.20 and 413.24. The Sixth Circuit did not need to reach the issue of whether PRM § 233 is a substantive rule independently of its conflict with 42 C.F.R. §§ 413.20 and 413.24. That is because the Sixth Circuit found that PRM § 233 does conflict with those binding regulations. However, both the *Amici Hospitals* explicitly argued in their cases in the District Courts, and *Mother Frances Hospital* argued in the Fifth Circuit, that PRM § 233 is a substantive rule under a straightforward APA analysis, without reference to whether it conflicts with the GAAP requirement imposed by 42 C.F.R. §§ 413.20(a) and 413.24. PRM § 233 is thus invalid not only because it conflicts with 42 C.F.R. §§ 413.20(a) and 413.24, but also because it is a substantive rule even if there were no such conflict.

II. PRM § 233 IS NOT AN INTERPRETATIVE RULE

In his decision, the only regulation of which the Administrator claimed PRM § 233 was interpretative was

42 C.F.R. § 413.9(b)(1).⁴ The Secretary’s argument that PRM § 233 is interpretative of 42 C.F.R. § 413.9(b)(1) relies upon selective quotation of that regulation out of context. The Administrator’s decision asserts that 42 C.F.R. § 413.9(b)(1) “requires payments to be based on ‘the actual cost of services rendered to beneficiaries during the year.’” Pet. App. at 47a. A reading of § 413.9(b)(1) in context reveals that the portion quoted is merely introductory in nature, and describes the effect of specific regulations that follow it in the Code of Federal Regulations. The full text of the last two sentences of 42 C.F.R. § 413.9(b)(1), in which the portion quoted by the Administrator appears, is as follows:

These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services, from both Medicare and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services furnished to beneficiaries during the year.

As can be seen, the phrase quoted out of context does not deal with advance refundings, or even with any general principle pertaining to attribution of costs to proper years. Instead, it explains the provisions of subsequent

⁴ Pet. App. at 47a. The Administrator cited the regulation as 42 C.F.R. § 405.451, and noted in a footnote that it has been recodified at 42 C.F.R. § 413.9. However, the only language from that regulation quoted by the Administrator in his decision is the phrase “the actual cost of services furnished to beneficiaries during the year,” which is now codified as 42 C.F.R. § 413.9(b)(1).

regulations which specify that Medicare will make retroactive adjustments at the end of the cost year to reconcile the difference between the estimated payments made on an interim basis by Medicare during a single cost year, and the costs that are finally determined after the yearly cost report is filed. The mechanics of these retroactive adjustments – which have nothing to do with the issues in this case – are treated by 42 C.F.R. §§ 413.60 and 413.64.

The reference to “accepted methods of cost apportionment” in 42 C.F.R. § 413.9(b)(1), it should be noted, does not refer to any method for apportioning costs *among years*. “Methods of cost apportionment” is a term of art under Medicare. Such methods include the “departmental method,” the “carve out method,” and the “cost per visit method.” See 42 C.F.R. § 413.53; see also 42 C.F.R. § 413.56. Use of a particular method of cost apportionment also has no bearing on the issues in this case.

Thus, the *only* reason why the phrase “during the year” appears in 42 C.F.R. § 413.9(b)(1) is to summarize the subsequent regulations dealing with retroactive adjustments. Those retroactive adjustments are used simply to reconcile estimated, interim payments for a given cost reporting year with the payment finally determined after the filing of the cost report. The Secretary’s artful quotations from the regulations, Pet. Br. at 31 – which are apparently designed to imply that the “cost apportionment” and “cost finding” methods relate to allocations *among years* (which they do not) – should not be allowed to obscure the fact that these regulations deal with the mechanics of interim payment and reconciliation, not with issues bearing on this case. PRM § 233 sets forth detailed rules on losses from advance refundings, and

cannot reasonably be held to be interpretative of a regulation dealing with retroactive adjustments, which is a completely separate subject.

42 C.F.R. § 413.9(b)(1) is plainly inapplicable to advance refundings, and no court case has sustained PRM § 233 as “interpretative” of that regulation. Therefore, the Secretary has in her recent appellate arguments, in the Fifth Circuit and in this Court, attempted to add or substitute different regulations of which she now claims PRM § 233 is interpretative.

Apart from 42 C.F.R. § 413.9(b)(1), the Secretary now newly cites four regulations or groups of regulations which she claims “provide ample ‘legislative authority’ for reimbursement of bond issuance costs incurred by providers and the allocation of such reimbursement to particular periods”⁵ Pet. Br. at 39. The Amici Hospitals will consider these four regulations in order.

First, the Secretary argues that the “regulations authorize reimbursement of ‘capital related costs’ that are ‘appropriate and helpful in . . . maintaining the operation of patient care facilities.’” *Id.* She cites 42 C.F.R. § 413.9(b)(2) for this proposition, with a “see generally” citation to 42 C.F.R. §§ 413.130-413.157. But 42 C.F.R. § 413.9(b)(2) does not even mention “capital-related costs.” It is simply a definition of “necessary and proper costs,” a term used elsewhere in the regulations. The “see

⁵ The Secretary repeatedly refers to “bond-issuance costs” as being at stake in this case. Pet. Br. at 39. The Court should be aware that it is not “bond-issuance costs,” which arise upon the issuance of new debt, that are at issue here, but rather a loss on the defeasance of the old bonds. “Debt issuance costs,” by the admission of the Intermediary’s own witness, are not part of the controversy over the loss. Admin. Rec. 347 (Andrews).

generally" citation to 42 C.F.R. §§ 413.130-413.157 adds nothing to the analysis. That citation is to the entirety of "Subpart G - Capital-Related Costs" of the Medicare regulations. It is not disputed that capital-related costs are reimbursable. The Secretary points to no specific regulation contained in Subpart G of which PRM § 233 is allegedly interpretative, except as noted below.

Second, the Secretary cites 42 C.F.R. §§ 413.130(a)(7) and (g) from Subpart G. Pet. Br. at 39. This citation is extraordinary in several respects. In the *Mother Frances* case, the Secretary adopted a similar approach, citing on appeal numerous regulations that had not been relied upon by the Administrator. The only portion of 42 C.F.R. § 413.130 cited by the Secretary in *Mother Frances* was § 413.130(a)(10), treating "debt issuance costs." In that case, *Mother Frances Hospital* pointed out that the costs at issue are not "debt issuance costs" but costs associated with early extinguishment of existing debt.⁶ Furthermore, 42 C.F.R. § 413.130(a)(10) was not promulgated until more than eight years after PRM § 233 became effective. 56 Fed. Reg. 43358, 43456 (Aug. 30, 1991).

The Secretary apparently now no longer contends that PRM § 233 is "interpretative" of a regulation promulgated more than eight years after PRM § 233 was issued. Instead, the Secretary has now plucked out two new subsections of 42 C.F.R. § 413.130, and tries to rely upon those subsections instead of § 413.130(a)(10).

Reliance on those two subsections - §§ 413.130(a)(7) and (g) - is similarly unavailing. The subsections relied upon were also published after PRM § 233 was issued.

⁶ Similarly, "debt issuance costs" are not at stake in the case at bar. See n. 5, above.

PRM § 233 was adopted by Transmittal No. 288, dated May 1983. 1 Medicare & Medicaid Guide (CCH) ¶ 5182. By its terms, it is "effective for all refundings initiated on or after July 1, 1983." PRM § 233.1, Pet. App. 85a. §§ 413.130(a)(7) and (g) were not published as an interim final rule until September 1, 1983, two months *after* the effective date of PRM § 233. See 48 Fed. Reg. 39752, 39809, 39810 (Sept. 1, 1983). It is difficult to accept that PRM § 233 is "interpretative" of regulations that were not yet in existence when it was issued.

Substantively, §§ 413.130(a)(7) and (g) add nothing to the analysis in this case. The combined effect of those two regulations is simply to state that interest expense for acquiring land and/or depreciable assets, or for refinancing existing debt used to acquire land and/or depreciable assets, is categorized as a capital-related expense. 42 C.F.R. § 413.130 was promulgated in 1983, as the Medicare "prospective payment system" or "PPS" was going into effect. Thus, a regulation was needed to distinguish which costs are capital-related costs (and thus not covered under PPS) and which costs are not capital-related costs (which thus may be covered under PPS). That is the purpose of 42 C.F.R. § 413.130.

Third, the Secretary cites 42 C.F.R. §§ 413.153(a)(1) and (b)(1). Pet. Br. at 39. These regulations merely confirm that "necessary and proper" interest is an allowable cost, state that certain types of interest are not an allowable cost, and define "interest." They say nothing about bond defeasances or advance refundings, none of the definitions therein affect the issues in this case, and the Administrator's decision did not claim that PRM § 233 was interpretative of these regulations.

Fourth, the Secretary cites 42 C.F.R. §§ 413.5(a) and 413.9, with a "see" reference to 42 U.S.C. § 1395x(v)(1)(A)(i). Pet. Br. at 39. These regulations are cited for the proposition that "allowable costs be related to beneficiary care." *Id.* There is no contention in this case that the costs at issue are not related to beneficiary care or patient care, as it is more often phrased. If they were not related to patient care they would not be reimbursable. See 42 C.F.R. § 413.9(c)(3) ("amounts not related to patient care" are not "allowable," that is, are not reimbursable costs). But the Secretary in this case has admitted that the costs at issue are reimbursable, so the citation to these regulations is irrelevant.

Defendants' attempt to substitute the four regulations discussed above, besides being wholly unpersuasive, is a classic "*post hoc* rationalization" of counsel. *Motor Vehicles Manufacturers Ass'n of the United States v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29, 50 (1983) ("[T]he courts may not accept appellate counsel's *post hoc* rationalizations for agency action. . . . It is well established that an agency's action must be upheld, if at all, on the basis articulated by the agency itself").

The statutory provision governing reimbursement under this situation is the extraordinarily broad language of 42 U.S.C. § 1395x(v)(1)(A), requiring the Secretary to reimburse hospitals for their "reasonable costs." The Secretary has promulgated a number of regulations to outline what "reasonable costs" means in specific contexts, and the manner in which reimbursement will be made for those costs. But, as shown above, on the subject of the case at bar the regulations are utterly silent. The Secretary should not be permitted to leap from the bare language of

the statute saying "reasonable costs" should be reimbursed, to the kind of minutely detailed rules contained in PRM § 233, while skipping altogether the issuance of regulations. A decision that she may do so would vitiate the Secretary's obligation under the APA to comply with rulemaking requirements in the entire area of Medicare reasonable cost reimbursement to hospitals and other providers.

III. PRM § 233 IS NOT A GENERAL STATEMENT OF POLICY

The Secretary contends that PRM § 233 should be considered a "general statement of policy" under the APA. Pet. Br. at 38; 5 U.S.C. § 553(b)(A). Quite plainly, this is not the case. In an often cited decision, the D.C. Circuit defined general statements of policy as follows:

A general statement of policy, on the other hand, does not establish a "binding norm." It is not finally determinative of the issues or rights to which it is addressed. The agency cannot apply or rely upon a general statement of policy as law because a general statement of policy only announces what the agency *seeks to establish* as policy. A policy statement announces the agency's *tentative intentions* for the future. *When the agency applies the policy in a particular situation, it must be prepared to support the policy just as if the policy statement had never been issued.* (footnote omitted). An agency cannot escape its responsibility to present evidence and reasoning supporting its substantive rules by announcing binding precedent in the form of a general statement of policy.

Pacific Gas & Electric Co. v. Federal Power Commission, 506 F.2d 33, 38-39 (D.C. Cir. 1974). (emphasis added)

The D.C. Circuit has also recognized that the determination of whether an agency pronouncement is a "general statement of policy," or is in fact a "substantive rule," rests upon whether the agency in its actual course of conduct treats the pronouncement as binding. Some of these cases were summarized in *Public Citizen, Inc. v. Nuclear Regulatory Commission*, 940 F.2d 679, 682-83 (D.C. Cir. 1991):

[C]ases concerned with the policy statement/substantive rule distinction confirm that the agency's application of a disputed rule is crucial. See *Community Nutrition Inst. v. Young*, 818 F.2d 943, 949 (D.C. Cir. 1987) (notice-and-comment procedures required where the FDA, "by virtue of its own course of conduct", had given action levels a "present binding effect"); *Batterton v. Marshall*, 648 F.2d 694, 706 (D.C. Cir. 1980) (agency's course of conduct revealed that methodology was not merely a policy statement); see also *Vietnam Veterans v. Secretary of the Navy*, 843 F.2d 528, 539 (D.C. Cir. 1988) (agency application of a document in a flexible manner supports classification as a policy statement) [further citations omitted].

The D.C. Circuit in *Public Citizen* went on to note that even a policy that might initially be thought to be a general statement of policy might later be recategorized "based on actual applications of the policy" *Id.* at 683. Indeed, "a policy initially classed as a general statement [of policy] is not immunized from subsequent judicial review for conformity with the APA if later developments show the agency to be using it as binding policy." *Id.* (quoting *American Hospital Ass'n v. Bowen*, 834 F.2d 1037, 1057 n.4 (D.C. Cir. 1987)).

Although the Secretary attempts to characterize PRM § 233 as a "general statement of policy," the Secretary has

clearly given it binding effect in practice. In at least twelve cases, the PRRB after hearing record evidence attempted to depart from PRM § 233's rule requiring amortization.⁷ In each instance, the Administrator reversed the PRRB.⁸ Furthermore, the Intermediary's own

⁷ *University of Michigan Hospitals (Ann Arbor, Mich.)*, PRRB Dec. 93-D96 (Sept. 23, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,743; *St. Mary's Regional Medical Center (Reno, Nev.)*, PRRB Dec. 93-D53 (July 1, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,583; *Grant Medical Center (Columbus, Ohio)*, PRRB Dec. 93-D3 (Nov. 27, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,941; *Lourdes Hospital Group*, PRRB Dec. 92-D57 (Sept. 3, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,837; *Fort Worth Osteopathic Medical Center (Fort Worth, Tex.)*, PRRB Dec. 92-D39 (July 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,413; *Michigan Osteopathic Medical Center (Detroit, Mich.)*, PRRB Dec. 92-D36 (June 18, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,369; *Henry County Memorial Hospital (New Castle, Ind.)*, PRRB Dec. 92-D26 (Mar. 25, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,171; *Dominican Santa Cruz Hospital (Santa Cruz, Cal.)*, PRRB Dec. 92-D23 (Mar. 6, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,120; *Mother Frances Hospital (Tyler, Tex.)*, PRRB Dec. 92-D11 (Feb. 13, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,014; *Graham Hospital Association (Canton, Ill.)*, PRRB Dec. 91-D87 (Sept. 30, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,698; *St. Johns Regional Medical Center Group Appeal*, PRRB Dec. 91-D76 (Sept. 6, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,789; *Guernsey Memorial Hospital (Cambridge, Ohio)*, PRRB Dec. 90-D50 (Aug. 16, 1990), Medicare & Medicaid Guide (CCH) ¶ 38,908.

⁸ *University of Michigan Hospitals*, HCFA Admin. Dec. (Nov. 19, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,954; *St. Mary's Regional Medical Center*, HCFA Admin. Dec. (Aug. 30, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,764; *Grant Medical Center*, HCFA Admin. Dec. (Jan. 6, 1993), Medicare & Medicaid Guide (CCH) ¶ 41,079; *Bond Defeasance Group*, HCFA Admin. Dec. (Oct. 27, 1992), Medicare & Medicaid Guide (CCH) ¶ 41,060; *Fort Worth Osteopathic Medical Center*, HCFA Admin. Dec. (Sept. 9, 1992), Medicare & Medicaid Guide (CCH)

witness in this case testified that PRM § 233 is binding on the Intermediary. Admin. Rec. 357.

Thus, PRM § 233 cannot realistically be regarded as announcing "the agency's tentative intentions for the future." PRM § 233 explicitly states that it is "effective for all refundings initiated on or after July 1, 1983." Pet. App. 85a. Furthermore, PRM § 233 essentially codified, with some significant changes, a previously enforced administrative rule requiring amortization of advance refunding losses under PRM §§ 215 and 215.1.

PRM § 233 sets forth detailed payment rules that have been enforced without exception by the Secretary in a binding manner. PRM § 233 is a substantive rule, not a general statement of policy.

IV. THE SECRETARY HAS NOT SUPPORTED PRM § 233, WHICH SHE CONTENDS IS NON-BINDING, BY SUBSTANTIAL EVIDENCE

As noted in *Pacific Gas & Electric*, 506 F.2d at 38, if a pronouncement is a "general statement of policy" it has no binding effect and "[w]hen the agency applies the

¶ 40,870; *Michigan Osteopathic Medical Center*, HCFA Admin. Dec. (Aug. 14, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,836; *Henry County Memorial Hospital*, HCFA Admin. Dec. (May 22, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,746; *Dominican Santa Cruz Hospital*, HCFA Admin. Dec. (May 5, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,749; *Mother Frances Hospital*, HCFA Admin. Dec. (Mar. 30, 1992), Medicare & Medicaid Guide (CCH) ¶ 40,778; *Graham Hospital Association*, HCFA Admin. Dec. (Nov. 27, 1991); *St. Johns Regional Medical Center Group Appeal*, HCFA Admin. Dec. (Nov. 8, 1991), Medicare & Medicaid Guide (CCH) ¶ 39,792; *Guernsey Hospital*, HCFA Admin. Dec. (Dec. 12, 1990), Medicare & Medicaid Guide (CCH) ¶ 38,910.

policy in a particular situation it must be prepared to support the policy just as if the policy statement had never been issued."

Assuming *arguendo* that PRM § 233 is not a substantive rule and is non-binding, is the Administrator's decision supported just as if PRM § 233 "had never been issued"?

Clearly, it is not. The Secretary, in quoting the APA test for review of agency action, repeatedly quotes only the requirement that agency action not be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." Pet. Br. at 37. But the specific test set forth in the APA for review of agency decisions such as the one at bar is that such decisions must be reversed if they are "unsupported by substantial evidence in a case . . . reviewed on the record of an agency hearing provided by statute." 5 U.S.C. § 706(2)(E). In this case such a hearing was provided by statute. The hearing before the PRRB, with further review by the Administrator, is provided by 42 U.S.C. §§ 1395oo(a); *see also* 42 U.S.C. § 1395oo(f). The Medicare statutes expressly provide that the decision of the PRRB "shall be based upon the record made at such hearing," and "shall be supported by substantial evidence when the record is viewed as a whole." 42 U.S.C. § 1395oo(d). Judicial review, by statute, is made "pursuant to the applicable provisions under Chapter 7 of title 5," that is, pursuant to the APA, including 5 U.S.C. § 706. 42 U.S.C. § 1395oo(f).

As this Court has held, an agency must "articulate [a] rational connection between the facts found and the choice made" *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962); *Motor Vehicles Manufacturers Ass'n*, 463 U.S. at 43. An agency order must "be

upheld, if at all, on the same basis articulated in the order by the agency itself." *Burlington Truck Lines*, 371 U.S. at 168-69; see also *Biloxi Regional Medical Center v. Bowen*, 835 F.2d 345, 351 n.18 (D.C. Cir. 1987) (if PRRB did not itself rely on a particular factor, "it cannot properly be urged in support of the PRRB's decision").

Agency action will be invalidated if the agency "offer[s] an explanation for its decision that runs counter to the evidence before the agency." *Motor Vehicles Manufacturers Ass'n*, 463 U.S. at 43.

Defendants' argument that this Court should give deference to the Secretary's actions due in part to her "significant expertise," Pet. Br. at 29, ignores the fundamental administrative law principle that "[a]gency expertise is not . . . a substitute for evidence in the record." 5 J. Stein, G. Mitchell, and B. Mezines, *Administrative Law* § 51.02, at 51-86 to 51-88 (rev. ed. 1994). The Supreme Court in *Baltimore & Ohio Railroad Co. v. Aberdeen & Rockfish Railroad Co.*, 393 U.S. 87, 91-92 (1968), declared:

We agree with the District Court that there is no substantial evidence that territorial average costs are necessarily the same as the comparative costs incurred in handling North-South freight traffic. If we were to reverse the District Court, we would in effect be saying that the expertise of the [Interstate Commerce] Commission is so great that when it says that average territorial costs fairly represent the costs of North-South traffic, the controversy is at an end, even though the record does not reveal what the nature of that North-South traffic is. *The requirement for administrative decisions based on substantial evidence and reasoned findings - which alone make effective judicial review possible - would become lost in the haze of so-called expertise. Administrative expertise would then be on its way to*

becoming 'a monster which rules with no practical limits on its discretion'. . . . That is impermissible under the Administrative Procedure Act. (emphasis added)

The Administrator's purported justification for the amortization rule adopted in PRM § 233, and applied in his decision in this case, runs counter to the administrative record. According to the Administrator's decision, PRM § 233 "reflects the economic reality of a bond refunding on the cost of furnishing services to Medicare beneficiaries," Pet. App. 47a, and "the loss is a cost of rendering patient care over several years." *Id.* at 49a. Because the loss was found by the Administrator to relate to rendering patient care over future periods, PRM § 233 allegedly protects the program against "cross-subsidization" of non-Medicare patients by the government if Medicare utilization should decrease or if providers should "drop out of the Program before services are rendered to Medicare beneficiaries in those future years." *Id.*

The key passage in the Administrator's decision is as follows:

The loss is a cost of rendering patient care over several years. By amortizing the loss to match it to Medicare utilization over the years to which it relates, the program is protected from any drop in Medicare utilization Further, the program is protected from making a payment attributable to future years and then having the provider drop out of the Program before services are rendered to Medicare beneficiaries in those future years.

Id.

The linchpin of the Administrator's decision is, therefore, the contention that the loss is for future periods, after the year in which the defeasance occurred.

The Administrator's cross-subsidization argument depends upon that factual finding, since the cross-subsidization argument has force, if at all, only if hospitals that have engaged in advance refundings were to drop out of the Medicare program, or have decreasing Medicare utilization, in those future years to which the costs allegedly related.

The administrative record, however, clearly demonstrates that the loss on defeasance is not a cost incurred by the provider in future years.

Under its governing statute, the Medicare program reimburses providers only for costs "actually incurred." 42 U.S.C. § 1395x(v)(1)(A). The testimony of both the provider's expert witness, and the Medicare intermediary's witness, established that after the year of the advance refunding transaction the provider is no longer liable for repayment of the refunded debt. Admin. Rec. 273 (Langenfeld); J.A. 24 (Andrews). After an advance refunding transaction, the provider no longer carries costs of the refunded debt on its financial records. J.A. 14-15 (Huelskamp). Payments on the refunded debt are made by the trustee, not the hospital, and any costs are "incurred" by the trustee. J.A. 24-25 (Andrews). After the advance refunding transaction, the bond holders of the old bonds have no recourse against the provider. Admin. Rec. 235-36 (Huelskamp). For the purposes of the hospital, the old debt has "ceased to exist" after the defeasance. Admin. Rec. 263 (Langenfeld).

As shown by the testimony of Mr. Langenfeld of Ernst & Whinney, the loss on defeasance, if it relates to any year other than the year of the defeasance transaction, would relate to past periods, not future periods. J.A.

20-21, 23; Admin. Rec. 306. The loss is simply a recognition of the difference between the net carrying costs of the old bonds and the price necessary to reacquire the bonds. Admin. Rec. 256, 262, 267-68. In other words, the loss occurred because, due to declining interest rates, the cost of reacquiring the bonds increased compared to the value at which the bonds were carried on the hospital's books. That loss would occur regardless of whether any new debt, extending into future years, had been contemporaneously issued. Admin. Rec. 265-67 (Langenfeld).

Because the outcome of the instant case may control the outcome of the *Mother Frances* and *Osteopathic Medical Center* cases filed by the Amici Hospitals, it should be noted that Mr. Langenfeld's testimony also formed part of the stipulated administrative record in those two cases. In addition, the record in those two cases included testimony from two other expert witnesses on behalf of the providers. It did not include Ms. Andrews' testimony, but instead the testimony on behalf of the Medicare fiscal intermediary was furnished by Mr. Wilson Leong.⁹

In the *Mother Frances* and *Osteopathic Medical Center* cases, Mr. Leong attempted to support the Administrator's "economic reality" argument by proffering the view that "the actuality of the situation is that the debt has not been liquidated." This exchange then occurred:

Question: The actuality of the situation?

Answer: The factual matter is bond holders have not received the payments.

⁹ Mr. Leong originally testified in the *St. John's* case, cited in nn. 7 and 8, above.

Question: Where in the Medicare regulations is there support for this perspective that you are now imposing? This actuality theory?

Answer: *In regulation, we don't have any.*

Administrative Record of *Mother Frances* case at 672 (filed as part of Record Excerpts in Fifth Circuit) (emphasis added)

No witness testified in the instant case as to any hospitals dropping out of the Medicare program,¹⁰ or provided any testimony that Medicare utilization was likely to decrease in future years. The record is thus devoid of any support for the Administrator's "cross-subsidization" theory. It is the purest form of speculation.

Even if it were accepted that the loss on defeasance relates to patient care in the future (which it does not), and that Medicare utilization is likely to decrease rather than increase (a highly unlikely assumption given the aging of the population), it is virtually impossible that cross-subsidization of non-Medicare patients by Medicare would occur. The Congressional Budget Office ("CBO") and the Prospective Payment Assessment Commission ("PROPAC") estimate that in 1991 Medicare payments covered only 88 percent of the costs that hospitals incurred in treating Medicare patients, and that the total payments that hospitals received for treating Medicaid patients equalled approximately 82 percent of the costs

¹⁰ As the Secretary is undoubtedly aware, few if any hospitals would consider dropping out of the Medicare program. Despite the history of Medicare underpayment, the program usually provides a large percentage of hospital revenues. In the case at bar, the testimony showed that Guernsey Memorial Hospital's Medicare utilization rate was approximately 67%. Admin. Rec. 187 (Huelskamp).

hospitals incurred in treating Medicaid patients.¹¹ The CBO and PROPAC agree that Medicare and Medicaid underreimbursed hospitals by \$15.1 billion in 1991. Both the CBO and PROPAC studies recognize that hospitals use payments from privately insured patients to cover costs that are not fully reimbursed by Medicare and Medicaid. Cross-subsidization thus certainly occurs. But it is massively in the direction of private payors subsidizing Medicare, not the other way around.

It is to prevent agencies from issuing edicts based on nothing more than unsupported speculation that both the rulemaking and "substantial evidence" procedural safeguards were adopted by the APA. In formulating rules for future application, the agency must proceed by a publicly accountable, quasi-political process of substantive rulemaking. In adjudications conducted without benefit of a substantive, binding rule, it must support its decisions by substantial evidence. Here the agency has done neither.

¹¹ Congressional Budget Office Paper, "Responses to Uncompensated Care and Public-Program Controls on Spending: Do Hospitals 'Cost Shift'?" (May 1993); Prospective Payment Assessment Commission, "Medicare and the American Health Care System, Report to Congress" (June 1993). The CBO was established pursuant to the Congressional Budget Act of 1974. PROPAC is appointed by the Director of the Congressional Office of Technology Assessment pursuant to 42 U.S.C. § 1395ww(e)(2)(A). Copies of these public documents will be furnished to the Court on request.

CONCLUSION

For the reasons stated above, the decision of the Sixth Circuit Court of Appeals should be affirmed.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1993

DONNA E. SHALALA,
Secretary of Health and Human Services,
Petitioner,
vs.
GUERNSEY MEMORIAL HOSPITAL,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE
AMERICAN HOSPITAL ASSOCIATION,
THE FEDERATION OF AMERICAN HEALTH
SYSTEMS, THE CALIFORNIA ASSOCIATION
OF HOSPITALS AND HEALTH SYSTEMS,
AND THE TEXAS HOSPITAL ASSOCIATION
IN SUPPORT OF RESPONDENT

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QUESTIONS PRESENTED

1. Whether the Secretary of Health and Human Services' denial of respondent's claim for its reasonable costs incurred according to generally accepted accounting principles or GAAP conflicts with Medicare regulations.

2. Whether, if Medicare regulations do not require GAAP be used to determine Medicare allowable costs, a guideline relied upon by the Secretary to deny reimbursement is invalid under the Medicare Act and the Administrative Procedure Act.

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<i>Broadway Community Hosp. v. Blue Cross Ass'n, et al.,</i> PRRB Dec. No. 82-D94 (1982), Medicare & Medicaid Guide (CCH) ¶ 32,00115
<i>Comprehensive Home Health Care, Inc. v. Blue Cross and Blue Shield Ass'n, et al.,</i> PRRB Dec. No. 91-D21 (1991), Medicare & Medicaid Guide (CCH) ¶ 39,08416
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<i>HCA Home Office Stock Option Group Appeal v. Blue Cross and Blue Shield Association, et al.,</i> PRRB Dec. No. 85-D49 (1985), Medicare & Medicaid Guide (CCH) ¶ 34,63015

<i>Methodist Hosp. of Lexington, Inc. v. Blue Cross & Blue Shield Ass'n</i> , HCFA Admin. Dec. (1991), Medicare & Medicaid Guide (CCH), ¶ 39,469 <i>aff'd, Methodist Hosp. of Lexington, Inc. v. Sullivan</i> , C.V. No. 91-2684-HB (W.D. Tenn. 1993)	17
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Social Security Amendments of 1965, S. Rep. No. 404, 89th Cong., 1st Sess. (1965) <i>reprinted in U.S.C.C.A.N. at 1976</i>	30
Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 149-172 (1983)	4
Omnibus Budget Reconciliation Act of 1987, H. Rep. No. 100-391(I), 100th Cong., 1st Sess. § 4073 (1987) <i>reprinted in</i> <i>U.S.C.C.A.N. at 2313-250</i>	28

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American Institute of Certified Public Accountants, <i>Audits of Providers of</i> <i>Health Care Services</i> , § 3.01 (1993)	7
Robert A. Anthony, <i>Interpretive Rules,</i> <i>Policy Statements, Guidance,</i> <i>Manuals, And The Like — Should</i> <i>Federal Agencies Use Them To Bind</i> <i>The Public?</i> 41 Duke L.J. 1311 (1992)	28

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Attorney General's Manual on the Administrative Procedure Act (1947)	18, 22
Kenneth C. Davis, <i>Administrative Law Treatise</i> , § 6.3 (3rd Ed. 1994)	23
HCFA Form 2552-92 (9/93), reprinted in Medicare and Medicaid Guide (CCH), Report No. 773 (Oct. 29, 1993)	13

INTEREST OF *AMICI CURIAE*

With the written consents of both parties, which have been filed with the Court, *amici curiae* respectfully submit this brief in support of respondent Guernsey Memorial Hospital.

Amici curiae are four hospital associations. The American Hospital Association ("AHA"), an Illinois corporation, is the primary organization of hospitals in the United States. AHA represents approximately 5,400 hospitals and other health care institutions. The Federation of American Health Systems, a New York corporation, represents approximately 1,400 investor-owned hospitals and 350 managed hospitals throughout the country. The California Association of Hospitals and Health Systems and the Texas Hospital Association are organized under the laws of their respective states and are the statewide hospital organizations in their states. *Amici's* members include most of the nation's hospitals.

The overwhelming majority of *amici's* institutional members participate as providers of services in the Medicare program. 42 U.S.C. §§ 1395-1395ccc. Payments made to hospitals on behalf of beneficiaries of the Medicare program account for approximately 40% of the revenue of most member hospitals. Reimbursement for services furnished to Medicare beneficiaries is a major factor considered by such hospitals in their financial planning, and can affect the continued ability of hospitals to provide needed services to Medicare beneficiaries and others in the community. Accordingly, *amici* have an immediate and continuing concern regarding the consistent application of the Medicare statute and implementing regulations, as well as the integrity and reliability of the procedures used to implement changes

in the reimbursement rules applicable to Medicare providers.

At issue in this case is an attempt by the Secretary of Health and Human Services ("Secretary") to avoid her own regulations regarding accrual basis accounting and generally accepted accounting principles ("GAAP"), as well as her attempt to bypass the rulemaking requirements of the Administrative Procedure Act, 5 U.S.C. § 551 *et seq.* ("APA"), in her administration of the Medicare program. *Amici* suggest that the Court reject the Secretary's efforts to reinterpret her rules regarding the applicability of GAAP to Medicare cost determinations. Moreover, the Court should reject the Secretary's attempt to issue legislative rules through the Provider Reimbursement Manual ("PRM") without regard to rulemaking procedures. Instead, this Court should adopt the reasoning of the court of appeals below, which properly applied the clear terms of the Secretary's regulations addressing GAAP, and which is consistent with the APA and the critically important policy considerations underlying it.

SUMMARY OF ARGUMENT

As the court of appeals found below, the Secretary seeks to avoid the plain terms of her Medicare regulations which provide that Medicare costs are to be determined in accordance with GAAP. These regulations do not exist simply by reason of the Secretary's general rulemaking authority, but were specifically mandated by the Medicare statute which requires the issuance of regulations to establish the method or methods to be used to determine Medicare costs.

In claiming that the regulations at issue here do not provide for GAAP, neither the final agency decision

below, nor the Secretary's brief here, addresses the terms of her regulations. Read as a whole, the regulations create a direct relationship between provider books and records maintained in accordance with GAAP and the determination of Medicare costs. They specifically link provider records to the cost determination process.

For many years, final agency decisions have interpreted the regulations in question to require the application of GAAP in determining Medicare costs. The Secretary has argued before the courts that GAAP applies pursuant to her regulations, particularly where GAAP would reduce Medicare costs. The Secretary has taken inconsistent positions regarding the application of GAAP under her regulations, however, depending on her litigating strategy.

The Secretary's current interpretation of the regulation is designed to avoid the notice and comment rulemaking requirements of the APA. If the regulations do not establish GAAP as the primary basis for determining Medicare costs, the Secretary asserts that she need not comply with the APA in issuing rules that are inconsistent with GAAP. Because Congress has directed the Secretary to exercise her legislative rulemaking authority through regulations, however, she is not free to establish a method of determining costs through a mere interpretive rule. The rule at issue in this case is a substantive rule that can be adopted only in accordance with the procedural requirements of the APA. Any other result would seriously threaten the integrity of the rulemaking process.

ARGUMENT

I. THE SECRETARY'S MEDICARE REGULATIONS REQUIRE GAAP AND ACCRUAL BASIS ACCOUNTING BE USED IN DETERMINING MEDICARE COSTS UNLESS OTHERWISE PROVIDED BY REGULATION.

A. The Secretary's Construction Of Her Regulations Violates Their Clear Terms.

The Medicare statute, 42 U.S.C. § 1395x(v)(1)(A), requires that the actual reasonable costs incurred by providers for services to beneficiaries "shall be determined in accordance with regulations establishing the method or methods to be used"¹ Regulations implementing this mandate appear at Title 42 C.F.R., Part

¹ Effective for cost reporting periods beginning on and after October 1, 1983, Medicare directed that most hospitals in the country be paid their operating costs, not on the basis of their reasonable cost, but on the basis of prospectively determined rates. However, the Secretary continued to pay certain costs, including costs defined as capital-related costs, on the basis of reasonable costs actually incurred. Social Security Amendments of 1983, Pub. L. No. 98-21, §§ 601-607, 97 Stat. 149-172 (1983). The costs involved in this case are deemed by the Secretary to be capital-related costs and were paid on a reasonable cost basis. For cost reports beginning on or after October 1, 1991, capital-related costs are also paid on a prospectively determined basis. See 42 U.S.C. § 1395ww(g)(1)(A).

Because virtually all costs of hospital inpatient services are now paid under Medicare's prospective payment system, the future significance of the specific regulations at issue in this case is greatly diminished. The issue of whether the Secretary is required to issue regulations with respect to Medicare's payment system remains of extreme importance to *amici* and its members.

413, and are entitled "Principles of Reasonable Cost Reimbursement."

Although amended and supplemented, these principles have been in place since the beginning of the Medicare program. See 31 Fed. Reg. 14,808 (Nov. 22, 1966), codified at 20 C.F.R. §§ 405.401-405.454 (1968).² The reimbursement regulations address the specific treatment of certain kinds of costs such as depreciation, interest, costs associated with bad debts, costs involving transactions between related organizations, and costs of educational facilities. See 42 C.F.R. §§ 413.134, 413.154, 413.80, 413.17 and 413.85 (1993), respectively. In addition to the specific cost matters addressed, the regulations have, since the program's beginning, addressed provider financial records and the application of accrual basis accounting for purposes of determining allowable costs. These latter regulations are found at 42 C.F.R. §§ 413.20 and 413.24.

The Secretary claims that these sections by their terms do not require the use of GAAP and accrual basis accounting to determine Medicare costs.³ Brief for the

² These regulations were recodified at 42 C.F.R. § 405.401 *et seq.* in 1977. See 42 Fed. Reg. 52,826 (Sept. 30, 1977). In 1986, the regulations were redesignated at 42 C.F.R. Part 413. See 51 Fed. Reg. 34,794 (Sept. 30, 1986).

³ The overwhelming weight of authority, including the court of appeals below and three other federal courts of appeals, have disagreed with the Secretary and found that the regulations at §§ 413.20 and 413.24 mandate the use of GAAP and accrual basis of accounting in determining how Medicare costs are paid. See, e.g., *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994); *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179, 1181 (9th Cir. 1989); *Charlotte Memorial Hosp. & Med. Center v. Bowen*, 860 F.2d 595, 600 (4th Cir. 1988); *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa* (continued)

Petitioner ("Pt. Br.") at 27. Instead, she claims these regulations only impose record-keeping requirements on hospitals. But her argument makes only passing reference to the actual terms of these regulations and ignores their requirements in the context of the regulatory scheme.

As the court of appeals in its decision below noted, the language in 42 C.F.R. § 413.20(a) requiring that hospitals follow standardized accounting practices that are widely accepted in the hospital field, "does not exist in a vacuum." Appendix to Petitioner's Brief ("Pet. App.") at 11a. This requirement exists in the context of the "principles of cost reimbursement" referred to in the prior sentence of the regulation which requires "that providers maintain sufficient financial records and statistical data *for proper determination of costs payable under the program.*" 42 C.F.R. § 413.20(a) (emphasis added). The Secretary interprets this provision to require that financial records be maintained consistently with widely accepted reporting practices, so that under some *other* system-wide method of determining costs, unstated in her regulations, the costs payable under the program will be properly determined. Under the Secretary's construction, there is a vague relationship between hospital financial records and the determination of costs which does not appear in the regulations.

The district court in Maine dismissed the Secretary's argument as requiring two separate accounting systems to be maintained, stating:

(fn. continued)
View Community Hosp., Inc. v. Heckler, 720 F.2d 1086, 1093 n.18 (9th Cir. 1983).

The [Secretary's] argument is illogical. The Secretary mandates certain record keeping requirements precisely because the provider is entitled to reimbursement of reasonable costs. . . . To suggest that the Secretary required providers to seek reimbursement under one accounting system while he intended to make payment under another is contrary to the structure of the regulations.

Mercy Hospital v. Sullivan, (D. Me. 1991), reported at Medicare & Medicaid Guide (CCH) ¶ 40,227 at 30,603 (quoting *St. Luke's Hosp. v. Secretary of Health & Human Serv.*, 632 F. Supp. 1387, 1391 (D. Mass. 1986), vacated on other grounds, 810 F.2d 325 (1st Cir. 1987)).

Contrary to the Secretary's position, her regulations provide for a direct relationship between the maintenance of hospital financial records and books of account and the proper determination of costs payable under the program. As noted, the first sentence of § 413.20(a) addresses the principles of cost reimbursement which require that sufficient data be maintained "for proper determination of costs payable under the program." This sentence, standing alone, strongly suggests that the data maintained by the provider is the basis for determining costs. Next, according to the subsection, hospitals must maintain their books and records in accordance with standardized definitions, accounting, statistics and reporting practices that are widely accepted in the hospital and related fields. Generally accepted accounting principles have always provided the standard definitions and accounting practices applied by non-government hospitals in maintaining their books and records. See, e.g., American Institute of Certified Public Accountants, *Audits of Providers of Health Care Services*, § 3.01 (1993) ("Financial statements of health care entities

should be prepared in conformity with generally accepted accounting principles.") No other standardized definitions exist for such hospitals or are widely accepted so far as is known to *amici*.

Immediately following the requirement that standardized definitions, accounting, statistics, *etc.*, be followed is the provision that changes in hospital accounting practices and systems will not be required "in order to determine costs payable under the principles of reimbursement." This sentence does not provide that a hospital's financial records will be adapted in some manner to accommodate the methods to be announced by the Secretary for determining costs. Instead, it reaffirms that costs will be determined from the hospital's financial records without requiring that those records be modified.⁴

The last sentence of § 413.20(a) states that "the methods of determining costs payable under Medicare involve making use of data available from the institution's basic accounts, as usually maintained, to arrive at equitable and proper payment for services to beneficiaries." The only natural reading of the sentence is that the "basic accounts as usually maintained" form the basis for determining costs payable under the program.⁵ Otherwise, how are the "basic accounts as usually main-

⁴ As the court of appeals below stated, the Secretary can, of course, depart from GAAP by validly issued regulations. See Pet. App. at 6a.

⁵ Section 413.20(d) specifies provider record-keeping requirements in some detail. It requires providers to furnish information to intermediaries regarding several matters including costs of operation. 42 C.F.R. § 413.20(d)(2)(vii). Under the Secretary's construction, the record-keeping requirements of subsection (d) regarding costs of operation are superfluous.

tained" involved in the methods of determining costs?⁶

The accrual accounting regulation at § 413.24 is even more specific in its application to the determination of costs to be paid by Medicare. Referring only to subsection (b) of this regulation which defines the accrual basis of accounting, the Secretary concludes that the regulation addresses only the manner in which information must be "reported" in a provider's books, but not how it is to be used in determining costs. See Pt. Br. at 24-25. But the regulation is actually much more specific.

Subsection (a) refers to "cost data" which must be provided to the Secretary to support payments to providers for their reimbursable costs. The "cost data" must be based on providers' financial and statistical records which can be verified by audit and must be based on the accrual basis of accounting. See 42 C.F.R. § 413.24(a), (b). Subsection (e) of the regulation confirms that the cost data maintained in accordance with the accrual basis of accounting is the basis on which costs are determined. It provides that "[t]he cost data submitted must be based on the accrual basis of accounting *which is recognized as the most accurate basis for determining costs.*" (emphasis added). This statement, coupled with the requirement that cost data must be submitted on the accrual basis of accounting in order to support payments to providers, leaves no doubt as to the use of accrual basis accounting in the cost determination

⁶ The Secretary answered this question in her brief to the court of appeals for the ninth circuit by representing that "the regulations provide that the *essential methods of determining reimbursable costs* 'involve making use of data available from the institution's basic accounts as usually maintained. . . .' 42 C.F.R. § 405.406(a)." (emphasis added). See Brief for Appellee at 4-5 filed in *HCA Health Services of Midwest, Inc. v. Bowen, Secretary of Health and Human Services*, 869 F.2d 1179 (9th Cir. 1989).

process. Not even the Secretary's reinterpretation can avoid the regulation's plain language which provides that accrual basis accounting is the most accurate basis for determining costs rather than merely a record-keeping standard.

The claim that § 413.20 serves only a record-keeping purpose is assertedly supported by reference to its original placement at the end of what the Secretary considers "prefatory sections" of the initial Medicare regulations. Pt. Br. at 26. In fact, the Secretary has made clear that this regulation is part of the reasonable cost reimbursement rules. Prior to 1986, former § 405.406 (now § 413.20) was included with other regulations under a center heading of "Reasonable Cost Reimbursement: General Rules" and former § 405.453 (now § 413.24) was grouped with other regulations under a center heading of "Additional General Rules on Reasonable Cost Reimbursement." See 42 C.F.R. Part 413 (1984). The center headings, while not a part of the regulations themselves, demonstrate that the Secretary considered these regulations to be part of the general principles of reimbursement, and that they were intended to do more than "provide general reassurance to providers" that their accounting practices would not have to be changed. Pt. Br. at 26.

Under the center headings, former §§ 405.406 and 405.453 were grouped with regulations which set forth *mandatory* principles of reimbursement. For example, immediately following former § 405.406, and under the same center heading, was former § 405.414 which expressly limited the definition of, and reimbursement for, capital-related costs in a manner which departed from GAAP. See 42 C.F.R. § 405.414 (1984). Similarly, the placement of § 405.453 with a group of regulations under the center heading "Additional General Rules on

Reasonable Cost Reimbursement" groups it with other regulations which specify the manner in which costs are to be determined. It was not until the regulations were redesignated from Part 405 to Part 413 in 1986 that the Secretary grouped §§ 413.20 and 413.24 together under a center heading entitled "Accounting Records and Reports." See footnote 2, *supra*. Far from supporting the Secretary's claim that these regulations were intended as record-keeping rules only, it is clear from the placement of the regulations until 1986 that they were part of the Secretary's mandatory reimbursement principles which were applied in determining Medicare costs.⁷

As the court of appeals stated below, the Secretary cannot ignore the structure of her regulations in interpreting their terms. See Pet. App. at 11a. As this Court noted in a case involving the construction of statutory language, "the court must look to the particular . . . language at issue, as well as the language and design of the statute as a whole." *K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988).

If §§ 413.20(a) and 413.24 do not impose GAAP as the basic method for determining costs, then no regulation exists which specifies an overall methodology to be applied in the cost determination process. This absence not only violates the clear instructions of Congress contained in 42 U.S.C. § 1395x(v)(1)(A), but leaves a void in the method to be applied by hospitals in determining their Medicare costs. The Secretary claims that this void is filled by the Foreword to the PRM and/or by the

⁷ The district court below, apparently unaware that the Secretary retitled these sections in 1986, concluded that § 413.20 did not deal with cost reimbursement, in part, because it was titled "Financial Data and Reports." *Guernsey Memorial Hosp. v. Sullivan*, 796 F. Supp. 283, 290-91 (S.D. Ohio 1992).

Secretary's Federal Register notice published at 41 Fed. Reg. 46,291, 46,292 (Oct. 20, 1976), each of which direct GAAP be used only when a cost situation is not otherwise addressed. See Pt. Br. at 28, 30 n.17. But these notices do not conform to the statute's requirement that regulations issue to establish the methods to be used in determining costs. The Secretary seeks to minimize the importance of GAAP by arguing that it is only a "stop-gap" in the cost determination process because GAAP is only applied for cost situations not otherwise covered by her policies. Pt. Br. at 28. Even if this were true, the use of GAAP as a comprehensive "stop-gap" to Medicare cost determinations would surely be such a fundamental element in the reimbursement system as to constitute one of the methods to be used in cost determinations; as such, it could only be implemented by regulation as required by § 1395x(v)(1)(A).

But far from a "stop-gap," it is clear that hospitals' books and records, as maintained under GAAP, form the *primary* basis on which Medicare costs are determined. In fact, the Secretary's cost reporting forms and instructions require that the cost report be completed from the financial records and basic books of accounts of the provider.⁸ The cost report instructions require that the initial schedule of the cost report, entitled "Worksheet A," incorporate the trial balance of expense accounts from the provider's accounting books and records. PRM, Part II, Ch. 28, § 2807, *reprinted in Medicare & Medicaid Guide* (CCH), Report No. 773, dated October

⁸ Cost reports are the forms used by providers to claim their Medicare allowable costs. See 42 C.F.R. §§ 413.20(b), 413.24(f). Cost reporting forms contain numerous schedules which incorporate most categories of costs directly from a provider's books and records. See PRM, Part II, Ch. 28, which sets out the provider cost reporting forms and instructions.

29, 1993. The trial balance of expense accounts is a summary of the various expense ledgers maintained by the provider in accordance with GAAP. Moreover, the provider is required to certify that the cost report "is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted." See HCFA Form 2552-92 (9/93), *reprinted in Medicare & Medicaid Guide* (CCH), Report No. 773, dated October 29, 1993.

Rather than specifically addressing the language of her regulations, the Secretary, citing to her "broad authority" to determine the method or methods of reimbursement, asserts that she is not obligated by statute to apply GAAP and accrual accounting as the basis for her cost reimbursement principles, and that GAAP and Medicare have different objectives. Pt. Br. at 19-23. However, there is no inconsistency between these assertions and the conclusion that the regulations require GAAP as the method of determining costs. The Secretary, faced in 1966 with the need to develop a comprehensive system of cost reimbursement principles, wisely adopted one which was already available, widely recognized, in use, and fully comprehensible to providers. While it is possible to conceive of a system to determine costs other than GAAP and accrual basis accounting, none has been suggested by the Secretary.⁹ Nor does she refer to any interpretation, whether judicial or administrative, which would reasonably provide an alternative to the use of GAAP as the fundamental basis for determining reasonable costs.

If, as the Secretary asserts, GAAP is not the frame of reference in her regulations for determining allowable

⁹ The Secretary could, of course, have mandated cash basis accounting as the basis for determining costs.

costs, then the regulations are silent as to the relationship between financial records and Medicare allowable costs. More importantly, there would be *no regulation* under which costs are uniformly and systematically determined, leaving a "black hole" in the regulations regarding the methods to be used in that determination.

B. The Secretary's Agency Decisions Are Inconsistent With Her Present Construction Of The Regulations.

The Secretary claims that her interpretation of the regulations is supported by consistent and long-standing agency practice and interpretation. Pt. Br. at 28. But this claim is contradicted by the agency's prior actions in applying the same regulations. In numerous final agency decisions, the Secretary concluded that her regulations at §§ 413.20(a) and 413.24 (and their predecessor regulations at 42 C.F.R. §§ 405.406(a) and 405.453 (1984)) specifically provide for the application of GAAP and accrual basis accounting in determining costs. For example, in *Dr. David M. Brotman Memorial Hospital v. Blue Cross Association, et al.*, HCFA Admin. Dec. (1980), Medicare & Medicaid Guide (CCH) ¶ 30,922 at 9839, the Deputy Administrator not only held that § 405.406 requires that GAAP be followed, but applied GAAP in lieu of a PRM provision which treated the particular expense in a manner inconsistent with GAAP. He held that: "Under 42 C.F.R. 405.406, the determination of costs payable under the program should follow standardized accounting practices. . . . In this regard, under generally accepted accounting principles, credit card sales would be recorded individually at the full amount of the sale when the transaction occurred . . ." and concluded that credit card costs should be treated as

an expense rather than a reduction of revenue as required by a Medicare directive to the contrary.

Similarly, in *Biscayne Medical Center v. Blue Cross Association, et al.*, HCFA Admin. Dec. (1982), Medicare & Medicaid Guide (CCH) ¶ 32,304 at 9499, the Deputy Administrator held that the costs in question could not be recognized as reimbursable, stating, "[u]nder 42 C.F.R. 405.453, Medicare cost finding and reimbursement is based on the accrual basis of accounting. Under this method, a potential receivable would not be recorded as such in the provider's financial statements until it is definite and the amount can be reasonably determined. . . . In this case, the Medicare receivable is contingent upon the provider winning [another appeal issue]. Until the final determination . . . the provider cannot reasonably expect to receive any additional reimbursement."

In another final agency decision, *HCA Home Office Stock Option Group Appeal v. Blue Cross and Blue Shield Association, et al.*, PRRB Dec. No. 85-D49 (1985), Medicare & Medicaid Guide (CCH) ¶ 34,630 at 10,123, the Provider Reimbursement Review Board ("Board") upheld the intermediary's decision disallowing costs because it "implemented the requirements of 42 C.F.R. 405.406(a) that costs be defined . . . by following GAAP, as set forth in APB 25" The Board further concluded that "42 C.F.R. 405.453(a) and (b) require cost data [be maintained] on the accrual basis of accounting . . . [and] since 42 C.F.R. 405.453(a) requires that the subject cost be accrued, the providers did not fulfill that requirement. . . ." ¹⁰

¹⁰ To the same effect are: *Broadway Community Hosp. v. Blue Cross Ass'n, et al.*, PRRB Dec. No. 82-D94 (1982), Medicare & Medicaid Guide (CCH) ¶ 32,001 at 9889; *Rapides General Hosp. v.* (continued)

In litigation, the Secretary has also relied on GAAP to deny reimbursement of costs based on her regulations. See *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d at 1180-81. See also *National Medical Enterprises v. Bowen*, 851 F.2d at 293. Moreover, there has been no consistent agency practice to apply GAAP where Medicare program policies are silent. The Secretary has refused to apply GAAP where there was no Medicare directive to the contrary. For example, in *OrNda HealthCorp v. Shalala*, (E.D. Ark. 1993), reported at Medicare & Medicaid Guide (CCH) ¶ 41,975, appeal withdrawn, the Secretary rejected GAAP as the basis to determine the costs associated with a capital lease. Neither the regulations nor the PRM addressed capital lease costs and neither contained a provision for denying such costs. The district court reversed the Secretary's decision and concluded that GAAP and accrual accounting apply to determine the costs of capital leases

(fn. continued)

Blue Cross Ass'n, et al., PRRB Dec. No. 82-D35 (1982), Medicare & Medicaid Guide (CCH) ¶ 31,703 at 10,263; *Greene County General Hosp. v. Blue Cross and Blue Shield Ass'n, et al.*, PRRB Dec. No. 86-D38 (1985), Medicare & Medicaid Guide (CCH) ¶ 35,353 at 10,857; *Woodruff Community Hosp. v. The Travelers Ins. Co.*, PRRB Dec. No. 91-D40 (1991), Medicare & Medicaid Guide (CCH) ¶ 39,208 at 26,285; *Comprehensive Home Health Care, Inc. v. Blue Cross and Blue Shield Ass'n, et al.*, PRRB Dec. No. 91-D21 (1991), Medicare & Medicaid Guide (CCH) ¶ 39,084 at 25,466-67; *Woodland Park Hosp. v. Blue Cross and Blue Shield Ass'n, et al.*, PRRB Dec. No. 91-D30 (1991), Medicare & Medicaid Guide (CCH) ¶ 41,332 at 35,134; *National Medical Enterprises, Inc. Group Appeal*, PRRB Dec. No. 93-D2 (1992), Medicare & Medicaid Guide (CCH) ¶ 40,933 at 33,849-50; *Republic Health Group Appeal - Favorable Leasing v. Blue Cross and Blue Shield Ass'n, et al.*, PRRB Dec. No. 93-D11 (1993), Medicare & Medicaid Guide (CCH) ¶ 41,005 at 34,322.

pursuant to §§ 413.20 and 413.24.¹¹

Amici submit it is bad policy, as well as bad law, to permit the Secretary to rely on her regulations to apply GAAP when convenient, and to deny the applicability of those same regulations when it is not. The agency's inconsistent action in applying GAAP to determine costs substantially reduces any deference due the Secretary. See discussion in Brief For The Respondent at 20-21.

II. SECTION 233 OF THE PROVIDER REIMBURSEMENT MANUAL IS INVALID FOR FAILURE TO COMPLY WITH THE REQUIREMENTS OF THE MEDICARE ACT AND THE ADMINISTRATIVE PROCEDURE ACT.

A. The Medicare Statute And The APA Require That Substantive Rules Regarding Reimbursement Be Established By Regulation.

The Medicare statute at 42 U.S.C. § 1395x(v)(1)(A) expressly delegates to the Secretary legislative authority to give substantive meaning to the vague statutory concept of "reasonable costs" through regulations. See *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. 2151, 2154 (1993). As noted, the statute directs that regulations issue to establish the method or methods to be used in

¹¹ The Secretary has also refused to apply GAAP in other cases involving the cost of capital leases, although no Medicare directive addressing such costs exists. See, e.g., *Methodist Hosp. of Lexington, Inc. v. Blue Cross & Blue Shield Ass'n*, HCFA Admin. Dec. (1991), Medicare & Medicaid Guide (CCH), ¶ 39,469, *aff'd*, *Methodist Hosp. of Lexington, Inc. v. Sullivan*, C.V. No. 91-2684-HB, (W.D. Tenn. 1993) (unreported).

determining costs. If, as the Secretary asserts, her regulations are silent as to a systematic methodology for determining reasonable costs, PRM § 233 (which represents the Secretary's attempt to address one category of costs, those incurred in a bond defeasance) stands alone as a substantive rule which must be issued in accordance with the notice and comment rulemaking requirements of the APA. 5 U.S.C. § 553(b).¹²

There is no dispute that § 233 constitutes a "rule" as that term is defined in the APA. See 5 U.S.C. § 551(4). Nor is there any question that if § 233 is a "substantive" or "legislative" rule, it is subject to the requirements of the APA. See *Lincoln v. Vigil*, 113 S. Ct. 2024, 2033 (1993). While the term "substantive rule" is not defined in the APA, the Attorney General's Manual on the Administrative Procedure Act (1947) describes substantive rules as those "issued by an agency pursuant to statutory authority and which implement the statute. . . ." *Id.* at 30 n.3. The Court has characterized such rules as those "affecting individual rights and obligations." *Morton v. Ruiz*, 415 U.S. 199, 232 (1974). Such rules are deemed to "grant rights, impose obligations, or produce other significant effects on private interests." *Rosetti v. Shalala*, 12 F.3d 1216, 1222 n.15 (3rd Cir. 1993), citing *American Ambulance Serv. v. Sullivan*, 911 F.2d 901, 907 (3rd Cir. 1990) (quoting *Batterton v. Marshall*, 648 F.2d 694, 701-02 (D.C. Cir. 1980)).

The Court has recognized that § 1395x(v)(1)(A) does not merely authorize the Secretary to issue regulations but, in fact, "directs" the Secretary to promulgate regulations establishing methods to be used in determining

¹² The Secretary apparently concedes that if Medicare regulations require the application of GAAP in the determination of reasonable costs, § 233 of the PRM is invalid. See Pt. Br. at (I).

reasonable costs. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 210 (1988). "Rather than attempt to define 'reasonable cost' with precision, Congress empowered the Secretary to issue appropriate regulations setting forth the methods to be used in computing such costs." *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. at 2154. As the Court noted in *Good Samaritan Hospital*, aside from the agency's determination made pursuant to its regulations, there is no available standard of reasonableness. 113 S. Ct. at 2158. Therefore, in establishing methods for determining reasonable costs, the Secretary is not merely interpreting a statutory term. Instead, such rules implement the statute and grant rights, impose obligations and significantly affect private interests. Applying the definitions discussed above, they are substantive rules subject to the procedural requirements of the APA.

The Court has also recognized that where an express delegation is made by Congress, "[i]n exercising that responsibility, the Secretary adopts regulations with legislative effect." *Batterton v. Francis*, 432 U.S. 416, 425 (1977). The statutory delegation in that case appeared in Title IV of the Social Security Act, granting the Secretary the power to prescribe standards for determining when a father is unemployed for purposes of eligibility for benefits under the Aid to Families with Dependent Children Program. 42 U.S.C. § 607(a). Again in *Schweiker v. Gray Panthers*, 453 U.S. 34, 44 (1981), the Court recognized that the language of the Medicaid statute, 42 U.S.C. § 1396a(a)(17)(B), directing the Secretary to prescribe standards for determining the availability of income and resources, constituted an "explicit delegation of substantive authority" to define the term "available." In exercising her authority to define reasonable costs pursuant to the directive of

§ 1395x(v)(1)(A), the Secretary similarly exercises substantive authority and issues legislative rules.

Although the Secretary asserts that the regulations "already provide ample 'legislative authority' for reimbursement of bond issuance costs" (Pt. Br. at 39), the provisions relied on by the Secretary indicate to the contrary. The reader will search in vain among the regulations cited by the Secretary for any indication whatsoever regarding the methods (other than GAAP) to be applied in determining either the amount of, or the timing of, the bond defeasance costs incurred by a provider.¹³

The Secretary argues further that nothing in the APA or the Social Security Act "requires the agency to adopt every minute and detailed reimbursement policy and guideline as a 'substantive rule' with the force of law." Pt. Br. at 37. If the Court accepts her characterization of the regulations, however, not only has the Secretary issued § 233 (which she describes as a minute detail) without public participation, but GAAP as a basic principle of Medicare reimbursement has been adopted without the benefit of rulemaking.¹⁴

¹³ Aside from the application of GAAP, none of the cited regulations sets forth a method for determining such costs. Section 413.5(a) distinguishes the cost-based payment system from a fixed-rate system or prior cost system and sets forth basic principles of allocation of costs among payors; Section 413.9 establishes the principle that costs must be related to patient care, but refers the reader to other regulations for the methods of determining the cost on items included; Sections 413.130 and 413.153 establish that bond defeasance costs are among the types of costs allowable under Medicare, but provide no methodology by which the amount of cost recognized as allowable will be determined.

¹⁴ As the Secretary noted in her Brief to this Court filed on March 24, 1994 in *Thomas Jefferson University v. Shalala*, No. 93-120, the Secretary has "an explicit mandate to formulate regulations to define what reimbursement is due under the Medicare Program," citing 42 (continued)

Acknowledging that Medicare costs are determined by GAAP absent a contrary rule, the Secretary cites not her legally binding regulations, but introductory language in the Foreword to the PRM and a brief statement in the 1976 Federal Register publication. Pt. Br. at 28, 30 n.17. But this approach is an unprincipled one because the Secretary seeks to impose GAAP without a regulation so that she can depart from GAAP, not through properly adopted regulations, but through mere policy statements and manual provisions. Pt. Br. at 28, 30 n.17.

Moreover, the Secretary attempts to exercise unfettered discretion by virtue of an open-ended rule similar to that adopted by the Park Service in *United States v. Picciotto*, 875 F.2d 345 (D.C. Cir. 1989). In its regulations, the Park Service retained authority to impose "additional reasonable conditions" in issuing park permits for demonstrations and special events. See 36 C.F.R. § 796(g)(5)(xiii)(1988). The court concluded that the Park Service could not impose additional uniform restrictions without engaging in APA notice and comment rulemaking, and concluded that the Park Service's open-ended rule was an attempt by the agency to "grant itself a valid exemption to the APA for all future regulations and be free of APA's troublesome rulemaking procedures forever after, simply by announcing its independence in a general rule." *Id.* at 346-47.

Here, the Secretary goes one step further. Not only does she attempt to grant the agency an exemption to the APA, she attempts to establish the exemption through a

(fn. continued)
U.S.C. §§ 1395hh, 1395x(v)(1)(A). In that case, the Secretary addressed by regulation a "minute detail" of reimbursement involving community support of educational services which is far less significant than either § 233 or the application of GAAP. See Brief for Respondent, *Thomas Jefferson University v. Shalala*, at 21.

mere introductory statement in a Manual and a brief statement buried in a preamble accompanying the publication of a regulation. Under the Secretary's view, she need only adopt one basic regulation, such as 42 C.F.R. § 413.9(b), stating that all costs must relate to patient care, and all of the remaining details can be filled in through the PRM, bypassing the APA entirely. Such an approach was clearly not contemplated by Congress and is directly contrary to the APA.

B. Section 233 Is Not An Interpretive Rule.

The Secretary characterizes § 233 as an interpretive rule or policy statement.¹⁵ Interpretative rules are defined in the Attorney General's Manual on the Administrative Procedure Act (1947) as "rules or statements issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers" Generally, "[a]n interpretative rule simply states what the administrative agency thinks the statute means, and only 'reminds' affected parties of existing duties. On the other hand, if by its action the agency intends to create new law, rights or duties, the rule is properly considered to be a legislative rule." *General Motors Corp. v. Ruckelshaus*, 742 F.2d 1561, 1565 (D.C. Cir. 1984), *cert. denied*, 471 U.S. 1074 (1985) (citations omitted). Like all exceptions to the notice and comment requirement of the APA, the exception for interpretive rules is to be narrowly construed. See *Sentara-Hampton Gen. Hosp. v. Sullivan*, 980 F.2d 749, 759 (D.C. Cir.

¹⁵ Recognizing the prudence of allowing public input in the rulemaking process, the Secretary waived the grants and benefits exception of 5 U.S.C. § 553(a)(2) in 1971. 36 Fed. Reg. 2532 (Feb. 5, 1971).

1992) and cases cited therein. A rule is not interpretive merely because it sets forth the agency's interpretation of a statutory term. "A rule that performs [an] interpretative function is a legislative rule rather than an interpretative rule if the agency has the statutory authority to promulgate a legislative rule and if the agency intends to exercise that power." Kenneth C. Davis, *Administrative Law Treatise* § 6.3 at 235 (3rd Ed. 1994).

In this case, the Secretary cannot "remind" providers of the existing reasonable cost reimbursement methodology since, under the Secretary's construction, the regulations do not provide for such a methodology. Accordingly, § 233 does more than merely advise the public of the agency's construction of its rules; it creates new law regarding Medicare reimbursement for bond defeasance costs.

While various factors are considered in determining whether a rule is interpretive, the courts have looked to agency intent, as well as to the source and nature of the authority exercised, to distinguish between substantive and interpretive rules. Last year, the court in *American Mining Congress v. Mine Safety and Health Administration*, 995 F.2d 1106, 1112 (D.C. Cir. 1993), adopted a test which looks to the agency's intent to exercise delegated power in order to make such a distinction. The court stated that if any of the following four questions is answered in the affirmative, the rule is legislative, not interpretive: (1) whether in the absence of the rule there would not be an adequate legislative basis for enforcement action or other agency action to confer benefits or insure the performance of duties, (2) whether the agency has published the rule in the Code of Federal Regulations, (3) whether the agency has explicitly invoked its general legislative authority, or (4) whether the rule effectively amends a prior legislative rule. In this case,

the first and fourth tests must be answered in the affirmative.¹⁶

Applying the first test, there is no legislative basis in the regulations for § 233. Congress expressly left to the Secretary the responsibility for developing a payment methodology by regulation, since the term "reasonable costs" provided an inadequate basis for determining provider reimbursement. See *Good Samaritan Hosp. v. Shalala*, 113 S. Ct. at 2154. The Medicare regulation the Secretary purports to interpret by § 233 is 42 C.F.R. § 413.9. This regulation is simply a broad statement of the principles of reasonable cost reimbursement which provides no substantive guidance in determining when costs are to be recognized. In fact, the very regulation on which the Secretary relies states that reasonable costs "must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included." 42 C.F.R. § 413.9(b)(1) (1993) (emphasis added). The only regulations establishing the basic method for determining bond defeasance costs, and most other costs, are now disavowed by the Secretary. Therefore, in the absence of § 233, there would be no basis for the Secretary's denial of costs in this case.¹⁷

The fourth test of *American Mining Congress* is also met, since the Secretary has consistently applied GAAP as the underlying substantive methodology for determining Medicare reimbursement. As discussed in Section I above, GAAP has been the primary basis for determining

¹⁶ In fact, the third factor is also arguably met here, since the Secretary has cited 42 U.S.C. § 1395x(v)(1)(A) in support of § 233. Pt. Br. at 39.

¹⁷ In this regard, § 233 is similar to the many substantive rules the Secretary attempted to adopt without compliance with the APA which have been invalidated by the courts. See footnote 19, *infra*.

Medicare costs. Thus, whatever the source of authority to apply GAAP, it has been the only system-wide method applied by the Secretary. Section 233, requiring a determination in direct conflict with GAAP, effectively amends that prior legislative rule.

The court of appeals for the ninth circuit has adopted a similar analysis looking to "the source of the rule" in determining whether a rule can properly be characterized as interpretive. In *W.C. v. Bowen*, 807 F.2d 1502, 1504 (9th Cir. 1987), the court stated, "[i]f it is promulgated pursuant to statutory directive or under statutory authority, it is a substantive rule." (citation omitted). In *W.C. v. Bowen*, the Secretary was acting pursuant to a congressional directive to implement a program of reviewing decisions rendered by administrative law judges. There, as here, "[i]n exercising that discretion, the Secretary enacted a substantive rule." *Id.* at 1505.¹⁸ See also *Mt. Diablo Hosp. Dist. v. Bowen*, 860 F.2d 951 (9th Cir. 1988) (rejecting the Secretary's purportedly interpretive rule regarding the timing of certain Medicare bonus payments).

Similarly, the sixth circuit in *State of Ohio Department of Human Services v. United States Department of Health and Human Services*, 862 F.2d 1228, 1234 (6th Cir. 1988) found no existing regulatory authority for an eligibility ceiling the Secretary attempted to impose on the Ohio Medicaid program. The court concluded that the ceiling was in no way compelled by the regulation or the underlying statute at 42 U.S.C. § 1396a(a)(17). *Id.*

¹⁸ Where, as in this case, Congress directly commands an agency to issue regulations, such a duty "would not be satisfied with issuance of an humble interpretative rule." *Community Nutrition Inst. v. Young*, 818 F.2d 943, 953 (D.C. Cir. 1987) (Starr, J. concurring in part and dissenting in part).

Because the court concluded that the ceiling was not implicit in the regulation from the beginning, it could not be imposed later without compliance with the notice and comment requirements of the APA. *Id.* at 1236.

In this case, there is nothing explicit or implicit in the existing regulations on which to conclude that the method for determining bond defeasance costs imposed by § 233 would be applied. On the contrary, as discussed in Section I above, the regulations lead to the opposite conclusion. Where a rule results in a change in existing law or policy it is substantive in nature and, as a result, must be promulgated in accordance with the rulemaking requirements of the APA. *Nat'l Family Planning & Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227, 240 (D.C. Cir. 1992); *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986).

Moreover, the Secretary's decision to adopt a methodology contrary to GAAP through a mere interpretive rule or policy statement is inconsistent with her prior actions. The Medicare reasonable cost regulations reflect numerous instances in which the Secretary defined costs in a manner contrary to GAAP only after compliance with the APA rulemaking requirements. For example, 42 C.F.R. § 413.134, which addresses depreciation costs, is contrary to GAAP in that it modifies the determination of historical costs, limits the methodology for prorating costs over the useful life of an asset, and provides for the recapture of depreciation by the program upon a gain on the sale of an asset. *See also* 42 C.F.R. § 413.153(b)(2)(iii) (providing for an investment income offset to interest expense); 42 C.F.R. § 413.17 (providing for the recognition of costs relating to items or services obtained from related organizations); 42 C.F.R. § 413.134(h) (special treatment for sale and leaseback transactions).

The regulation adopted in the 1976 Federal Register publication cited by the Secretary here is another example of the Secretary's deviation from GAAP only after compliance with the APA. Following the APA's notice and comment rulemaking procedures, the agency adopted an approach to limit the amount of goodwill to be included in a provider's equity capital which was inconsistent with GAAP. 41 Fed. Reg. 46,291 (Oct. 20, 1976). Moreover, the Secretary continues to adopt rules contrary to GAAP through the APA rulemaking process. *See, e.g.*, 56 Fed. Reg. 50,834 (Oct. 9, 1991) (proposed rule modifying accrual basis accounting). In fact, according to the Secretary's regulatory agenda, she intends to issue a regulation regarding the application of GAAP to Medicare reimbursement determinations generally, presumably to adopt her litigating position in this case. 59 Fed. Reg. 20,312, 20,388 (Apr. 25, 1994).

C. Failure to Comply With APA Procedural Requirements Is Inconsistent With The Intent of Congress.

The APA rulemaking requirements which the Secretary seeks to avoid in this case, were designed to ensure fairness and mature consideration of rules of general application. *NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 764 (1960), *citing* H.R. Rep. No. 1980, 79th Cong., 2d Sess. 21-26 (1946); S. Rep. No. 752, 79th Cong., 1st Sess. 13-16 (1945). The procedures serve the dual functions of allowing the agency to benefit from the expertise and input of parties who file comments to the proposed rules and to see that the agency maintains a flexible and open minded attitude towards its own rules. *McLouth Steel Prod. Corp. v. Thomas*, 838 F.2d 1317, 1325 (D.C. Cir. 1988).

The Health Care Financing Administration has been among the federal agencies criticized for its frequent nonobservance of the APA in administering the Medicare and Medicaid programs.¹⁹ Robert A. Anthony, *Interpretive Rules, Policy Statements, Guidance, Manuals, And The Like — Should Federal Agencies Use Them To Bind The Public?* 41 Duke L.J. 1311, 1316 n.15 (1992). Congress was also concerned that "important [Medicare] policies are being developed without benefit of the public notice and comment period and, with growing frequency, are being transmitted, if at all, through manual instructions and other informal means." H. Rep. No. 100-391(I), 100th Cong., 1st Sess. § 4073 (1987), reprinted in U.S.C.C.A.N. at 2313-250. Accordingly, in 1987, Congress adopted 42 U.S.C. § 1395hh(a)(2), which mandates that "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . payment for services . . . shall take effect unless it is promulgated by the Secretary by regulation." Section 233, which clearly changes a substantive legal standard regarding payment, is precisely the type of rule that concerned Congress when it amended § 1395hh.

The Secretary's extra-record comment indicating that she attempted to comply with the spirit of the APA by

¹⁹ Numerous attempts by the agency to impose substantive rules through manuals and policy statements have been invalidated by the courts. See, e.g., *Mother Frances Hosp. of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994); *National Family Planning & Reproductive Health Ass'n, Inc. v. Sullivan*, 979 F.2d 227 (D.C. Cir. 1992); *State of Ohio Dep't of Human Serv. v. U.S. Dep't of Health & Human Serv.*, 862 F.2d 1228 (6th Cir. 1988); *Mt. Diablo Hosp. Dist. v. Bowen*, 860 F.2d 951 (9th Cir. 1988); *W.C. v. Bowen*, 807 F.2d 1502 (9th Cir. 1987); *Samaritan Health Serv. v. Bowen*, 811 F.2d 1524 (D.C. Cir. 1987); *Linoz v. Heckler*, 800 F.2d 871 (9th Cir. 1986).

discussing § 233 with a select group of interested parties illustrates the problems that result from failure to comply with the APA. Pt. Br. at 36 n.21. Such an informal procedure fails to assure the public participation required under the APA. Moreover, the Secretary's approach denies the public, as well as the courts, an adequate explanation of the basis and purpose of the rule. As a result of the Secretary's informal approach in this case, the Court is denied a complete and contemporaneous explanation of why the rule was promulgated. Such an explanation is essential to the Court's review of a rule in the face of a substantive challenge. See *Natural Resources Defense Council v. U.S. Envtl. Protection Agency*, 824 F.2d 1258, 1286 (1st Cir. 1987). Moreover, absent a rulemaking record, the Court cannot determine whether the agency fully considered those comments it received. "An agency decision may not be reasoned if the agency ignores vital comments regarding relevant factors, rather than providing an adequate rebuttal." *Abington Memorial Hosp. v. Heckler*, 576 F. Supp. 1081, 1085 (E.D. Pa. 1983), *aff'd*, *Abington Memorial Hosp. v. Heckler*, 750 F.2d 242 (3d Cir. 1984), *cert. denied, sub nom. Heckler v. Abington Memorial Hosp.*, 474 U.S. 863 (1985) (citation omitted). Here, the Court's only source of information regarding the "rulemaking process" is a self-serving memorandum prepared by the agency after the hearing at the Board and without opportunity for rebuttal. Joint Appendix at 6-8. Thus, the Secretary's informal process, far from meeting the intent of the notice and comment rulemaking requirements of the APA, actually flies in the face of that provision.

That Congress intended that the Secretary would exercise her delegated, substantive rulemaking authority in accordance with established rulemaking procedures is clear. First, the plain language of the statute mandates the issuance of regulations establishing the method or

methods to be used. 42 U.S.C. § 1395x(v)(1)(A). Moreover, in enacting this section, Congress recognized that it was providing only the broad framework for Medicare reimbursement determinations based on "reasonable costs," and directed that the methods to be used in determining reasonable costs "shall be developed in regulations of the Secretary. . . ." S. Rep. No. 404, 89th Cong., 1st Sess. *reprinted in* U.S.C.C.A.N. at 1976 (1965). Noting that issues relating to payment for hospital services had been "the subject of extended and painstaking consideration for more than a decade," Congress directed the Secretary to take "full advantage" of the experience of private agencies, organizations and associations in developing the regulations. *Id.* The Senate Report specifically noted, "[t]he concept of reasonable cost and the principles and methods for translating this concept into practice in individual circumstances are of concern to consumers, providers of services, insuring organizations, and State and Federal Governmental programs." *Id.* at 1977.

Rather than respond to the congressional directive to make use of the experience of private agencies and organizations, the Secretary seeks to avoid the opportunity to obtain public comment on her rules. Such an approach is not only inconsistent with the directive found in the Medicare statute, but it is inconsistent with the purpose and underlying philosophy of the APA.

CONCLUSION

The Judgment of the United States Court of Appeals for the Sixth Circuit should be affirmed.

Respectfully submitted,
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No. 93-1251

Supreme Court, U.S.
FILED

JUL 1 1994

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In The
Supreme Court of the United States
October Term, 1994

DONNA E. SHALALA, SECRETARY OF
HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Sixth Circuit

SUPPLEMENTAL BRIEF FOR THE RESPONDENT

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SUPPLEMENTAL BRIEF

Respondent hereby submits this Supplemental Brief, pursuant to Rule 25.5 of the Rules of the Supreme Court of the United States, to distinguish certain aspects of this Court's recent decision in *Thomas Jefferson University v. Shalala*, 1994 WL 276674, 62 U.S.L.W. 4601, 511 U.S. ___, 114 S.Ct. ___, 128 L.Ed.2d ___ (June 24, 1994), from the case currently pending before the Court.

The issue before this Court in *Thomas Jefferson University*, was the proper interpretation to be given to Medicare regulation 42 C.F.R. § 413.85(c). This regulation specifically dealt with the reimbursement of graduate medical education ("GME") costs. The Court was not asked to give force and effect to a provision of the Secretary's Provider Reimbursement Manual ("PRM") which conflicted with a regulation. In reaching its decision, the Court held that the Administrative Procedure Act ("APA"), 5 U.S.C. § 551, *et seq.*, required that deference be given to an agency's interpretation of its own regulation and that such deference was even more warranted in light of the fact that the Medicare program was "a complex and highly technical regulatory program" involving the "identification and classification of relevant criteria." *Id.* at 5. This Court also recognized, however, that an agency interpretation is entitled to considerably less deference when the Court is presented with persuasive evidence that the Secretary has acted in an inconsistent manner. *Id.* at 6.

Applying this standard, the Court held that the Secretary's construction of 42 C.F.R. § 413.85(c) was "faithful to the regulation's plain language." *Id.* at 7. The result of

the Court's decision was to create a factual question which must be resolved on a case by case basis as to how certain costs have been reported in the past by providers with GME programs.

As contrasted with the issue before the Court in *Thomas Jefferson University*, the present case does not involve the Secretary's interpretation of a regulation which specifically defines the reimbursement effect of a particular type of cost. In fact, it is the Respondent's position that there is no regulation which specifically deals with the issue of how to treat advance refunding losses other than general regulations requiring application of generally accepted accounting principles ("GAAP"). Rather, this Court is being asked to determine the propriety of the Secretary implementing section 233 of the PRM - a "rule" which has not been subjected to the APA's rulemaking process and which stands in direct conflict with the Secretary's own regulations (42 C.F.R. §§ 413.20, 413.24, and 413.5).

In addition, and as has been set forth in Respondent's Brief, as well as in the amici briefs supportive of Respondent's position, persuasive evidence exists that the Secretary has acted in an inconsistent manner in the application of GAAP to cases involving Medicare reimbursement. A decision by this Court striking down section 233 of the PRM will affirm the plain language of the relevant Medicare regulations.

As such, factors which the Court found persuasive in deferring to the Secretary in *Thomas Jefferson University* are completely lacking in the present case. For the above reasons and those already set forth in Respondent's Brief,

Respondent respectfully requests that the decision of the United States Court of Appeals for the Sixth Circuit be affirmed.

Respectfully submitted,

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JUN 17 1994

THE CLERK

In the
Supreme Court of the United States

OCTOBER TERM, 1993

DONNA E. SHALALA, Secretary of Health
and Human Services,
Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE
SIXTH CIRCUIT

BRIEF AMICI CURIAE OF
HOSPITALS PARTICIPATING IN
ST. JOHN HOSPITAL V. SHALALA
AND LOSS ON EXTINGUISHMENT
OF DEBT GROUP APPEAL
IN SUPPORT OF RESPONDENT

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Debt Group Appeal

Petition for Writ of Certiorari Filed February 1, 1994

Position for Writ of Certiorari Granted April 4, 1994

QUESTIONS PRESENTED

The Secretary of Health and Human Services (hereinafter "Petitioner" or the "Secretary") has presented the following questions for review:

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

Respondent Guernsey Memorial Hospital ("Hospital" or "Respondent") in Brief for the Respondent modifies Petitioner's characterization of the questions presented as follows:

1. Whether general Medicare reimbursement regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite a contrary administrative rule issued by the Secretary of Health and Human Services to govern reimbursement of advance refunding losses.
2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in delaying full reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act, and the Medicare statute.

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No. 93-1251

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**ON WRIT OF CERTIORARI TO THE UNITED STATES
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**BRIEF AMICI CURIAE OF HOSPITALS
PARTICIPATING IN *ST. JOHN HOSPITAL V. SHALALA*
AND *LOSS ON EXTINGUISHMENT OF DEBT*
GROUP APPEAL IN SUPPORT OF RESPONDENT**

INTEREST OF AMICI CURIAE

Amici curiae consist of the twenty-eight hospitals in the Medicare group appeal pending before the United States Court of Appeals for the Sixth Circuit in *St. John Hospital v. Shalala*, Case No. 93-2334, and fourteen hospitals pending in the Medicare group appeal pending before the Provider Reimbursement Review Board ("PRRB") in *Loss on Extinguishment of Debt Group Appeal*, PRRB Case No. 91-0500G. These hospitals collectively are referred to in this brief amici curiae as the "Group Appeal Hospitals."

The Court's decision in the instant case will be dispositive of the appeals in which The Group Appeal Hospitals are engaged.¹ The Group Appeal Hospitals, which comprise the overwhelming majority of hospitals appealing the issue presented by the instant case, submit this brief amici curiae on behalf of Hospital.²

From a Medicare payment perspective, it is primarily the time value of money that is at stake in the instant case and that is at stake for the Group Appeal Hospitals. The true, broad based significance of the Court's decision in this case is whether the Secretary is required to follow the Secretary's own regulations in determining Medicare payment.

The Secretary specifically has referenced *St. John Hospital* regarding the purported financial significance of the instant case, stating as follows: "The significant amount of money at issue in *St. John* will be irretrievably lost if review is deferred to await the development of a more specific conflict." *Petition for a Writ of Certiorari* at 14, n. 9.³

Although the Secretary claims that money "will be irretrievably lost," at issue is the proper *timing* of payment, not whether Hospital or the Group Appeal Hospitals are *entitled* to payment. Indeed, the Secretary ultimately concedes that

¹ The Group Appeal Hospitals in *St. John Hospital* also filed a brief amici curiae before the Sixth Circuit on behalf of Hospital. This brief amici curiae will not repeat the detailed statement of the case, statement of facts and description of the applicable Medicare reimbursement and accounting background that is set forth in the Brief for Respondent filed concurrently with this brief amici curiae.

² Hospital and the Secretary have consented in writing to the submission of this brief amici curiae.

³ This statement was made in the context of the Secretary's forecast of a conflict between the Fifth and Sixth Circuits, which proved to be inaccurate. Since the Court granted the *Petition for a Writ of Certiorari* absent a conflict between the Fifth and Sixth Circuits, presumably the *Petition for a Writ of Certiorari* was granted on this alternative basis. Thus, it seems appropriate that the amount in controversy be put in perspective for the Court.

"[i]n most cases, the amount of the allowable refunding loss is undisputed, and the only issue is whether the loss should be allowed in the year of the refunding transaction or amortized over some longer period." *Petition for a Writ of Certiorari* at 25. Thus, the Medicare program has incurred a cost for which the Medicare program is obligated to pay the Group Appeal Hospitals without regard to the outcome of this litigation. Moreover, because the advance refunding transactions of the Group Appeal Hospitals occurred in the mid to late 1980's, as a result of the passage of time most of the amortized payments under PRM § 233 for which the Medicare program is liable already have been paid.⁴ The average percentage difference in Medicare payment for the Group Appeal Hospitals is approximately 7% when payment is made under GAAP, as compared to payment as required by PRM § 233.⁵ While there is some slight increase in payment under GAAP as opposed to under PRM § 233, the Group Appeal

⁴ The Group Appeal Hospitals have been appealing this issue for upwards of five years. The Group Appeal Hospitals are entitled to payment of statutory interest under 42 U.S.C. § 1395oo(f)(2) should they prevail. The Secretary appealed *St. John Hospital* to the Sixth Circuit and moved to stay while the Secretary was evaluating whether to file a petition for certiorari in the instant case. In that motion, which initially was denied but subsequently was granted when the petition for certiorari was filed, the Secretary expressed no concern over the amount of interest accruing while it sought to delay the ultimate resolution of *St. John Hospital*. On the contrary, the Secretary's brief in support of its motion to stay *St. John Hospital* sought to justify delay of *St. John Hospital* in part on the fact that a statutory interest award would be included in the event the hospitals prevailed. Thus, the Secretary should not now have the right to inflate the amount in controversy by referring to statutory interest. Moreover, the Group Appeal Hospitals respectfully submit that they need not offer an apology that in the event they prevail they are entitled under law to an award of interest.

⁵ This slight increase is explained by the fact that the Secretary imposed reductions in Medicare capital payment subsequent to the years in which *St. John Hospital* underwent advance refunding transactions. By receiving payment under GAAP, *St. John Hospital* received the full amount of payment in the year and at the then applicable rate at which they were entitled to receive payment.

refunding."²³ Indeed, the Secretary acknowledges this crucial

²³ The record established before the Provider Reimbursement Review Board below is replete with uncontradicted evidence that Hospital was discharged of the old debt. This fact is evidenced in the Termination of Lease and Supplemental Lease, Release and Discharge of Indenture of Mortgage and Supplemental Indenture of Mortgage and Release of Guaranty, a copy of which is set forth in the *Joint Appendix* at 50-52. The Court's particular reference is directed to the following statement:

"NOW, THEREFORE, the Issuer, the Lessee [*i.e.*, Hospital] and the Trustee hereby agree, confirm and declare that . . . the Original Indenture and the Supplemental Indenture have been and are satisfied and, by this instrument, release, cancel and discharge the Original Indenture and the Supplemental Indenture." *Joint Appendix* at 52.

This fact also is evidenced by the uncontradicted testimony of Donald Huelskamp: "That's correct. Paragraph 3D is where the debtor is legally released from being the primary obligor under the debt, which is the situation that we have incurred in the Guernsey Memorial Hospital situation." *Joint Appendix* at 17. This fact also is evidenced by the uncontradicted testimony of Douglas E. Langenfield: "In reality in 1985 the hospital relieved itself of any obligation of the 1972 and 1982 bonds . . ." *Joint Appendix* at 17.

Further confirmation of this fact was requested by the Provider Reimbursement Review Board during the hearing below. This confirmation was provided by Hospital's legal counsel in Exhibit A to *Provider's Post-Hearing Brief* dated October 10, 1989: "[W]e advise you that the 1972 Bonds and the 1982 Bonds have been deemed paid and discharged within the meaning of the Prior Indenture, and the Hospital has been released and discharged from any further obligation to pay debt service on the 1972 Bonds and the 1982 Bonds." *Joint Appendix* at 11 (Emphasis supplied).

Testifying on behalf of the fiscal intermediary, Diane Andrews conceded the liability for the old debt was transferred to the trustee of the escrow account into which proceeds of the new debt had been deposited:

Q. Is it a cost incurred by the trustee?

A. The trustee would be making the actual payments.

Q. It was a cost incurred by the trustee in addition to making the payment, it was a cost incurred by the trust?

A. Yes.

fact: "[T]he establishment and funding of the escrow account released respondent from any further obligation to the holders of these bonds." *Brief for the Petitioner* at 8.

Because Hospital was no longer obligated on, and thus incurs no further loss relating to the old debt, the Medicare Act would prohibit, as an impermissible cross-subsidization, Hospital from being reimbursed for the cost of that debt in years after the advance refunding transaction. 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. § 413.9(b).²⁴ The Secretary also acknowledges the critical importance of this principle: "A central concern of 'reasonable cost' reimbursement is that any costs 'allowed' under Medicare must be properly matched to services provided to the program's beneficiaries during the applicable period." *Brief for the Petitioner* at 31-32.

Thus, the Secretary's argument that amortization is "reasonable" because it matches the cost of care in the year in which the care is provided is based on the undeniably false premise that Hospital remains liable on the old debt.²⁵ While the Secretary does not, and indeed cannot, deny this fact, the Secretary seeks to justify amortization by making an analogy "to allowable costs that relate to more than one accounting period — such as capital costs from which ben-

²⁴ The prohibition on cross-subsidization requires that Medicare not bear the costs of services to individuals who are not Medicare beneficiaries, and vice versa.

²⁵ The Secretary goes to great lengths to demonstrate to this Court that PRM § 233 is "rational," based on the statement of the Court of Appeals below that "there is nothing irrational about [PRM § 233]." Pet. App. 8a. This statement is a *dictum* to the holding that the Medicare Act requires the Secretary to promulgate regulations for the determination of reasonable cost. In the words of the Court of Appeals: "The Secretary's problem, of course, is that she has not done so." *Id.* 9a. This Court should affirm the decision of the Court of Appeals on the identical basis. Because the Secretary's principal argument appears to be a justification of PRM § 233, amici amplify Hospital's analysis by briefing the Court regarding the inherent errors in the Secretary's contentions. As cited in n. 30, *infra*, the Provider Reimbursement Review Board also found the Secretary's analysis to be flawed because it ignores that the debt has been defeased.

efits will be derived over several periods" *Brief for the Petitioner* at 32.

The Secretary's justification fails for several reasons. First, the payment at issue in this case is not for a capital cost. Second, the rationale for amortizing capital costs has nothing whatsoever to do with "benefits derived over several periods." Rather, capital costs are amortized to reflect that capital assets are consumed over several cost reporting periods rather than being fully used in one cost reporting period. See 42 C.F.R. §§ 413.134–413.144. In the context of this case in which Hospital no longer has liability under the old debt, applying the Secretary's logic a provider would continue to receive Medicare payment for a capital cost after the provider has disposed of, and long-since has relinquished legal title to, the capital asset.²⁶ Finally, the Secretary also amortizes a gain on advance refunding, when clearly the gain is not a "benefit" to the provider but rather an amount

²⁶ While amortization of capital costs has nothing to do with the "benefit" concept advanced by the Secretary, a more fitting analogy is the disposal of a capital asset. As with an advance refunding transaction, the disposal of a capital asset can result in a gain or loss. In essence, the Medicare program recomputes the useful life of the asset to reflect the early retirement of the asset. This recomputation of the useful life of the asset, depending upon the specific facts, could result either in a payment to the provider to reflect the provider's loss or an adjustment to reflect recapture of depreciation. Consistent with GAAP, these adjustments occur in their entirety in the year in which the capital asset is disposed. See 42 C.F.R. § 413.134 (f). In the case of Medicare payment for loss resulting from disposal, the Secretary generally does not amortize the payment over the remaining life of the disposed asset to reflect the "benefit" to the provider over that period. Similarly, where there is a recapture, which would be analogous to gain on advance refunding, the Secretary does not choose to amortize this detriment to the provider. Where there is an exception to the timing of recognition of gain or loss, it is done so by regulation. For example, an exception to the GAAP approach is made regarding the demolition or abandonment of assets resulting in losses in excess of \$5,000 and which are not 80 percent depreciated. In that instance, the loss is amortized over the remaining useful life of the demolished or abandoned asset. *Id.* § 413.134(f)(5)(iv). Of course, however, this non-GAAP approach is authorized by regulation.

the provider is required to pay to the Medicare program. *Henry County Memorial Hospital v. Shalala*, No. IP 92-1044-C (S.D. Ind. Feb. 23, 1994) Medicare and Medicaid Guide (CCH) ¶ 42,129.

Understood in light of the uncontested facts established before the Provider Reimbursement Review Board below, the application of GAAP, not the application of PRM § 233, accurately reflects the cost of patient care. The decision in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988) is particularly instructive regarding the proper analysis of the instant case.²⁷ As in the instant case, the court was faced with the question of whether GAAP should be applied in the absence of a Medicare regulation to the contrary. The court refrained from reaching the issue of the Secretary's authority to depart from GAAP without regulatory basis: "Even if the Secretary, in the absence of an enabling regulation, is authorized to prescribe a regulatory interpretation [*i.e.*, in the PRM] that conflicts with GAAP, a proposition we do not decide today, the Secretary would be at the very limit of his authority in so doing." 860 F.2d at 600. Instead, the court's analysis was based upon the theory that greater scrutiny is required: "The focus of this scrutiny is whether, with respect to the type of medical cost at issue, the departure from GAAP is supported by a showing that GAAP 'do not accurately reflect the cost of patient care, as opposed to the cost of running a business.'" *Id.* [citing *Villa View*.]²⁸

As in the instant case, in *Charlotte Memorial* the issue was the proper timing of payment of a Medicare cost, the allow-

²⁷ *Charlotte Memorial* was cited by the Court of Appeals below, although its holding that the Medicare regulations require the application of GAAP did not require it to engage in the analysis set forth in that decision. Pet. App. 10a, n.2.

²⁸ See n. 14, *supra* and accompanying text.

ability of which was not in dispute.²⁹ The court found that "GAAP provide the guiding light for determining when, under 42 C.F.R. § 413.24, a hospital incurs a reimbursable debt" *Id.* at 598. The court reasoned that "the GAAP approach . . . captures the tenor of the applicable regulation [*i.e.*, 42 C.F.R. § 413.24]" *Id.* at 599. The court explained that "[t]he core of the GAAP approach . . . is that, during each cost reporting period, cost reimbursements should rationally coincide with the real debt [incurred]." *Id.* at 601.

Accordingly, the court found that regardless of when the doctors received deferred compensation, the hospital incurred liability when it set aside the money to fund the deferred compensation. *Charlotte Memorial* teaches, therefore, that for purposes of determining when a cost is *incurred* under 42 C.F.R. § 413.24, reliance on GAAP is appropriate.³⁰ In the instant case, upon extinguishment of the old debt, Hospital has been legally discharged from the debt, no longer has reimbursable costs related to the old debt and, therefore, cannot subsequently be reimbursed for costs which legally have been transferred.

Application of GAAP, therefore, recognizes the crucial fact that Hospital is discharged from liability under the old

²⁹ The provider claimed reimbursement for funds that it set aside as deferred compensation for executives. The intermediary disallowed reimbursement for the funds set aside because they were not deposited in a plan which complied with the requirements of the PRM. Under the applicable GAAP, however, the set aside funds constituted a recognizable deferred compensation expense.

³⁰ The Provider Reimbursement Review Board below reached the very conclusion that GAAP properly matched costs in the year in which services were provided:

The loss was related to patient care in 1985, the year of the defeasance. The Board finds that the loss resulted from a change in the current market value of the debt. . . . [T]he entire loss or defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Pet. App. 71a.

debt. The Secretary's policy in PRM § 233, however, ignores this reality, and thus violates the statutory prohibition on cross-subsidization.

CONCLUSION

The Judgment of the United States Court of Appeals for the Sixth Circuit should be affirmed.

Respectfully submitted,

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Appeal

Hospitals achieved a huge savings to the Medicare program in the approximate aggregate amount of \$274,000,000 as a result of the advance refunding of debt.

The Secretary states that "[t]he issue is of continuing importance despite the ongoing transition to PPS reimbursement of capital-related costs." *Petition for a Writ of Certiorari* at 25, n.14. If the Group Appeal Hospitals are illustrative of hospitals appealing this issue, this statement is erroneous. In fact, only one of the Group Appeal Hospitals receives increased particular benefit under the Medicare capital prospective payment system methodology in the event their appeal is successful.⁶ All of the other Group Appeal Hospitals will receive a decreased Medicare payment under the capital prospective payment in the event their appeal is successful.

The continuing importance of this issue, therefore, is whether the Secretary is required to comply with the Medicare reg-

⁶ Medicare payment of capital-related costs for inpatient hospital services for cost reporting periods beginning or after October 1, 1991 is based on a prospective payment system methodology. 42 C.F.R. § 412.1-412.352. Under this methodology, a hospital-specific rate is computed based upon a hospital's capital-related costs during its base year, i.e., the cost reporting period ending on or before December 31, 1990. *Id.* 412.302(b). The hospital-specific rate is compared to a national average referred to as the "federal rate" and described in *Id.* 412.308. If the hospital-specific rate is less than the federal rate, the hospital receives a blended payment consisting of a hospital-specific rate component and the federal rate component over a ten-year transition period, with the hospital-specific rate component decreasing, and the federal rate component increasing, each year. *Id.* 412.340. This methodology is referred to as the "fully prospective" methodology. The Secretary's analysis contemplates this methodology. Thus, the Secretary's analysis assumes that all of the Group Appeal Hospitals underwent an advance refunding transaction during the base year, and that they all are paid under the fully prospective methodology. In fact, however, all but eight of the Group Appeal Hospitals have a hospital-specific rate higher than the federal rate, and all but one of those eight underwent an advance refunding prior to the base year. The remainder of the Group Appeal Hospitals are paid under a different methodology, referred to as the "hold harmless" methodology. *Id.* 412.344. Under the hold harmless methodology, only one of the Group Appeal Hospitals gains any payment advantage under this new capital-related cost payment methodology.

ulations the Secretary has promulgated as required by the Medicare Act. The United States Court of Appeals for the Sixth Circuit decided below that the Secretary is required to do so. Hospital demonstrates that no conflict exists among the federal courts, which unanimously support Hospital's position. The Group Appeal Hospitals seek to brief this Court that the decision of the Court of Appeals below also is consistent with well-established precedent, particularly with the line of cases decided by the United States Court of Appeals for the Ninth Circuit.

The Group Appeal Hospitals also seek to demonstrate for this Court that application of GAAP to determine the timing of Medicare payment for loss resulting from early extinguishment of debt through an advance refunding transaction is consistent with fundamental Medicare payment principles.

SUMMARY OF ARGUMENT

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually incurred . . . [which] shall be determined in accordance with regulations . . ." 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied). The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries.

In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court of Appeals below properly held that these regulations require, in the absence of a specific regulation to the contrary, the application of generally accepted accounting principles ("GAAP") in determining payment to Hospital for losses incurred in the early extinguishment of debt through an advance refunding transaction. The Court of Appeals correctly analyzed that the Secretary's payment policy, as set forth in Provider Reimbursement Man-

ual ("PRM") § 233, is not a regulation, and that therefore payment must be governed by the applicable regulations.

Hospital briefs this Court that the decision of the Court of Appeals below is consistent with the unanimous decisions rendered by the federal courts, which include decisions of the United States Court of Appeals for the Fifth Circuit and six district courts. This brief amici curiae demonstrates for the Court that the decision of the Court of Appeals below also is fully in accord with judicial precedent, including in particular a line of decisions issued by the United States Court of Appeals for the Ninth Circuit, the leading example of which is *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (9th Cir. 1983). The Secretary erroneously argued below, and argues before this Court, that *Villa View* and its progeny are mistaken, and that these decisions display what the Secretary terms "intra-circuit conflict." Careful review of this line of cases reveals that the Ninth Circuit and district courts situated in the Ninth Circuit properly and consistently have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.

In addition to the Ninth Circuit line of cases, virtually every reported case in which either a hospital or the Secretary urges the application of GAAP turns on whether a Medicare regulation, rather than a provision in the Medicare Provider Reimbursement Manual, governs payment contrary to GAAP. Thus, the decision of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, and accordingly should be affirmed by this Court.

Although the holding of the Court of Appeals below is consistent with the overwhelming weight of judicial authority, the Secretary goes to great lengths to convince this Court that PRM § 233 is "rational." This brief amici curiae demonstrates that while the application of GAAP reflects the crucial fact that Hospital has been discharged from the old or "refunded" debt, the Secretary's payment policy as set forth in PRM § 233 ignores this reality. The Medicare Act and the Medicare regulations prohibit the cross-subsidization

of Medicare beneficiaries by persons who are not Medicare beneficiaries, and vice versa. Because PRM § 233 ignores the reality that Hospital has been discharged from the refunded debt, the Secretary's payment policy results in a mismatch of costs and years in which Hospital provides services, and thereby works a statutorily prohibited cross-subsidization. Under the analysis established in *Charlotte Memorial Hospital and Medical Center v. Bowen*, 860 F.2d 595 (4th Cir. 1988), the application of GAAP in the instant case accurately reflects the cost of patient care.

ARGUMENT

I. THE WEIGHT OF JUDICIAL AUTHORITY HOLDS THAT THE SECRETARY'S REGULATIONS MANDATE THE APPLICATION OF GAAP IN THE INSTANT CASE

The Medicare Act requires the Secretary to reimburse Hospital for the "cost actually incurred . . . [which] shall be determined in accordance with regulations" 42 U.S.C. § 1395x(v)(1)(A) (Emphasis supplied).⁷ The regulatory scheme contemplated by the Medicare Act requires the Secretary to promulgate and comply with regulations defining the methods for reimbursing hospitals for services provided to Medicare beneficiaries. In implementing this regulatory scheme, the Secretary promulgated, among others, the regulations at 42 C.F.R. §§ 413.20 and 413.24. The Court's interpretation of these regulations is dispositive of the issue presented by the instant case.

⁷ Hospital does not contend, and to rule in favor of Hospital this Court need not hold, that the Medicare Act itself requires the application of GAAP. The use of the very term "incurred" in the Medicare Act, however, cannot be ignored. At a minimum, use of this term strongly suggests that reliance on accounting principles is necessary for the determination of costs.

The Court of Appeals below concluded that the regulation set forth in 42 C.F.R. § 413.20 contains

what appears to be a flat statement that generally accepted accounting principles are followed Were it not for § 233 [of the Provider Reimbursement Manual], any fair minded person reading the regulations in light of generally accepted accounting principles would have to conclude that Guernsey Hospital was entitled to reimbursement for its advance refunding costs in the year in which, under GAAP, the costs were deemed to have been incurred.

Guernsey Memorial Hospital, Pet. App. 6a. *Accord*, *Mother Frances Hospital of Tyler, Texas v. Shalala*, 15 F.3d 423 (5th Cir. 1994).⁸

Hospital briefs this Court that in addition to the Fifth and Sixth Circuits, six district courts have determined that the Secretary's own regulations require the application of GAAP in determining payment to hospitals for losses incurred in the early extinguishment of debt through an advance refunding. The Secretary, without addressing these cases in *Brief for the Petitioner*, summarily asserts that "the [Sixth Circuit] erred in discerning any such regulatory requirement." *Brief for the Petitioner* at 35.

This interpretation of these regulations by two Courts of Appeals and six district courts fully is in accord with precedent.⁹

⁸ "We agree with the reasoning of *Guernsey* and adopt its holding that the Medicare regulations provide for the use of GAAP in determining the timing of Medicare reimbursement in advance refunding transactions and that section 233, which provides to the contrary, is an invalid attempt to promulgate a substantive rule without complying with the rulemaking formalities." 15 F.3d at 426.

⁹ In contesting this interpretation, the Secretary also asserts that the Secretary's "understanding of the text of the regulations is confirmed by the Secretary's longstanding interpretation and consistent administrative practice." *Brief for the Petitioner* at 28. As demonstrated by the *amici curiae* brief filed on behalf of Respondent by Amici American Hospital Association *et al.*, however, review of applicable precedent reveals that

Notably, the decision of the Court of Appeals below is consistent with a line of decisions issued by the United States Court of Appeals for the Ninth Circuit ("Ninth Circuit") holding that the Secretary must apply GAAP in the absence of a regulation to the contrary (not just a Provider Reimbursement Manual ("PRM") provision), the leading example of which is *Villa View Community Hospital v. Heckler*, 720 F.2d 1086 (9th Cir. 1983).

The Secretary argues that *Villa View* and its progeny are mistaken because they somehow misconstrued the Ninth Circuit's earlier decision in *North Clackamas Community Hospital v. Harris*, 664 F.2d 701 (9th Cir. 1980). *Petition for a Writ of Certiorari* at 13-14. Finding questionable support only in a *dictum* in footnote 16 of *North Clackamas*,¹⁰ the Secretary concludes that *North Clackamas* stands for the principle that the Secretary can depart from GAAP through the PRM without the support of a regulation. Therefore, the Secretary concludes that the Ninth Circuit's decisions display "intra-circuit conflict." *Petition for a Writ of Certiorari* at 14.

The Secretary's misplaced reliance on footnote 16 of *North Clackamas* is immediately revealed upon further review of *North Clackamas*. In that case, the plaintiff hospital purchased another hospital and a portion of the purchase price was allocated to going concern value ("GCV"). The issue was whether the hospital was entitled to Medicare reim-

the position of the Secretary is not consistent. While this brief *amici curiae* shows that legal precedent follows a consistent thread, the brief *amici curiae* filed by American Hospital Association *et al.* shows that the Secretary's position fluctuates to achieve the outcome desired to suit specific circumstances. See, e.g., *HCA Health Services of Midwest, Inc.*, n.16, *infra*.

¹⁰ Footnote 16 of *North Clackamas* states in its entirety as follows:

The Secretary normally follows generally accepted accounting practices, 42 C.F.R. § 405-406(a) (1979), but when these practices do not accurately reflect the cost of patient care, as opposed to the cost of running a business, the Secretary reserves the right to prescribe different accounting practices. See 41 Fed. Reg. 46,292 (1976).

bursement for the portion of the purchase price allocated to GCV. 664 F.2d at 703. The threshold issue determined by the Provider Reimbursement Review Board ("Board") below in *North Clackamas* was the proper characterization of GCV. The Board found "that GCV 'was more akin to good will than to any other asset.'" *Id.* at 705. Significantly, the Board made this determination based upon GAAP.¹¹ The Board disallowed Medicare reimbursement for GCV, however, because a specific Medicare regulation, *i.e.*, 42 C.F.R. § 405.429(b)(2), explicitly provided that good will was not a reasonable cost reimbursable by the Medicare program. 664 F.2d 705, n.12. Of course, in the instant case it is undisputed that loss on extinguishment of debt is recognized as a Medicare reimbursable cost. In stark contrast to the instant case in which PRM § 233 is not supported by the Medicare regulations, the Board and the district court in *North Clackamas* relied upon a provision of the PRM which mirrored the provisions of the relevant regulation. *Id.* at 705, n.13. Therefore, *North Clackamas* supports the arguments of Hospital in this case that Medicare payment principles must be defined by Medicare regulations.

In *North Clackamas* the Ninth Circuit affirmed the Board's application of GAAP to characterize GCV, and affirmed the Board's application of the Medicare Regulations to determine that GCV was not a reimbursable cost.¹² Footnote 16,

¹¹ "This determination was in accordance with *standard accounting practices* made applicable by 42 C.F.R. § 405.406(a)(1979)" (redesignated as 42 C.F.R. § 413.20, 51 Fed. Reg. 34,790 (1986)) (Emphasis added). 664 F.2d at 705, n. 11. Thus, and as argued by the Hospital in the instant case, *North Clackamas* implicitly recognized that the Medicare Regulation at 42 C.F.R. § 413.20 requires the application of GAAP.

¹² Confirmation that the decision in *North Clackamas* turned on the application of the Medicare regulations is set forth in the decision of the United States District Court for the Central District of California in *Hollywood Presbyterian Hospital-Olmstead Memorial v. Bowen* (No. CV 87-2595, Sept. 2, 1988, Medicare and Medicaid (CCH) Paragraph 37,479). There, as in the instant case, the Secretary relied on a PRM provision that was unsupported by the Medicare regulations to deny reimbursement for

when read in conjunction with footnote 11 of that case as well as in the context of the holding, is authority for the principle on which this Court should decide the instant case, *i.e.*, that the Secretary is required to follow the Medicare regulations, and that the Medicare regulations mandate the application of GAAP.

The portion of *North Clackamas* footnote 16 stating that "the Secretary reserves the right to prescribe different accounting practices" is a mere *dictum*. It is erroneous for the Secretary to conclude based on this mere dictum that the Secretary need not follow the Secretary's own regulations. On the contrary, the law is clear that the Secretary has the right to prescribe different accounting practices only in the Medicare regulations. The Secretary misinterprets this *dictum* as authority for departing from GAAP in the PRM when there is *no* support for such a departure in a regulation. Certainly the dictum does not state that the Secretary can do so. Rather, the Secretary relies heavily on the reference in footnote 16 to the following Federal Register statement:

[GAAP] are applicable to Medicare cost determinations only when a cost situation is not covered by 42 C.F.R. Part 405 or a [PRM]. It is only in the absence of health insurance policy that GAAP should be followed.

Brief for the Petitioner at 30, n.17.

This statement appeared, however, not in the text of a regulation, but in the *preamble* to the October 20, 1976

an employer's Federal Insurance Contributions Act ("FICA") contribution to accrued but unused vacation time. As is evident by the following statement, that court clearly recognized the distinction between the case before it, in which no regulation supported the PRM, and the *North Clackamas* case, in which the decision was governed by the regulations:

The Secretary points to no specific principle embodied in the statute or regulations that would be contravened by the accrual of FICA taxes according to generally accepted accounting principles. Cf. *North Clackamas* (citation omitted) (amortization of goodwill held not reimbursable because attainment of profits is *unrelated to the delivery of needed health services*)

CCH, p. 18,504 (Emphasis added).

promulgation of an amendment to the Medicare regulations entitled "Limitations on Recognition for Equity Capital Purposes of Amounts Paid in Excess of Fair Market Value for Tangible Assets Acquired Prior to August 1970."¹³ The Secretary's very action of amending the Medicare regulations, rather than seeking to depart from the Medicare regulations through the PRM, belies the point which the Secretary and the District Court seek to make in relying on this preamble language. At most, this language evidences the Secretary's prior naked assertion that the Secretary need not adhere to the Secretary's own regulations.

Thus, the Secretary overlooks the issue, facts and holding in *North Clackamas* and relies on a misinterpretation of a *dictum* in footnote 16 to conclude that subsequent Ninth Circuit cases issued over the succeeding decade were decided in error. On the contrary, the Ninth Circuit and district courts situated in the Ninth Circuit properly have held that the Secretary is authorized to depart from GAAP only through the Medicare regulations.¹⁴

¹³ It is obvious that a preamble is not a regulation and does not have the force and effect of a regulation. Upon review of the entire preamble, it is apparent that the Secretary's actions belied the statement relied upon heavily by the Secretary that GAAP is "applicable to Medicare cost determinations only when a cost situation is not covered by [the Medicare regulations] or the Provider Reimbursement Manual." Having made this statement, the Secretary immediately contradicts it: "Because such program policy [in the form of regulations] is now being promulgated on this issue, generally accepted accounting principles are not applicable." 41 Fed. Reg. at 46,292. Moreover, while this statement was part of the Secretary's response to several commenters who argued that the Secretary's regulation regarding goodwill departed from GAAP, the Secretary responded "that the amendment is not contrary to 'generally accepted accounting principles.'" *Id.* Thus, this language is ambiguous and, in any event, does not have the force and effect of a regulation.

¹⁴ For example, in the leading case of *Villa View Community Hospital, Inc. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983) the Ninth Circuit was faced with this issue and clearly explained the statement in footnote 16 in *North Clackamas* that "the Secretary reserves the right to prescribe different accounting practices" as follows:

The Secretary erroneously asserts *Villa View* "mis-cited" *North Clackamas* because footnote 16 of *North Clackamas* did not specify that the Secretary's right to prescribe different accounting practices must be exercised by regulation. *Petition for a Writ of Certiorari* at 13-14. The Secretary overlooks that long before deciding *North Clackamas* or *Villa View*, the Ninth Circuit consistently has recognized that the Secretary must follow the Medicare regulations.¹⁵ In fact, the doctrine articulated in *Villa View* has been applied consistently by the Ninth Circuit in every subsequent case in which the Secretary sought to depart from GAAP other than by regulation.¹⁶ Additionally, the Ninth Circuit consistently

Thus, where the Secretary has not prescribed different accounting practices *by regulation*, the Secretary must apply generally accepted accounting principles.

720 F.2d at 1093, n.18 (Emphasis added).

¹⁵ For example, in March of 1980, nine months prior to issuing the decision in *North Clackamas*, the Ninth Circuit stated in a Medicare case: "It is by now axiomatic that agencies must comply with their own regulations while they remain in effect [citations omitted]." *Memorial, Inc. v. Harris*, 655 F.2d 905, 910, n.14 (9th Cir. 1980). Thus, *Villa View*'s explanation that the Secretary could depart from GAAP only through the regulations was merely stating a matter which had become axiomatic and which clearly did not originate with the *North Clackamas* decision. Although the District Court below accepted the Secretary's argument that *Villa View* misconstrued *North Clackamas*, it is respectfully submitted that the District Court's analysis is inconsistent with the foregoing review of these two decisions. Indeed, the Court of Appeals below itself agrees with the Ninth Circuit that "[a]n agency is bound by the regulations it promulgates and may not attempt to circumvent the amendment process through changes in interpretation unsupported by the language of the regulation." *Fluor Constructors v. Occupational Safety and Health Review Commission*, 861 F.2d 936, 939 (6th Cir. 1988).

¹⁶ In *Vista Hill Foundation, Inc. v. Heckler*, 767 F.2d 556 (9th Cir. 1985), the Secretary relied on the PRM to deny reimbursement based on educational expenses provided to patients of an acute psychiatric facility. In finding that the PRM provision was invalid in light of the Medicare Act and the Medicare regulations, the Ninth Circuit stated "in view of the regulations she [i.e., the Secretary] has chosen to adopt, the Secretary may not deny reimbursement for the educational services at issue in this

has recognized that the Medicare regulations, when specifically applicable, supersede GAAP.¹⁷ In the instant case the Secretary does not point to any Medicare regulation that supports the application of PRM 233 or otherwise supersedes GAAP. Accordingly, GAAP is determinative.

In addition to the Ninth Circuit line of cases, the Court should take notice that virtually every reported case in which either a hospital or the Secretary urges the application of

case." 767 F.2d at 566. Further, the Ninth Circuit recognized that while the Secretary might choose to "amend her regulations," in the interim "the Secretary has no choice but to follow the rules she has adopted." *Id.* That analysis is entirely applicable to the instant case.

Similarly, the Ninth Circuit made the following statement, which is equally applicable to the instant case, in *National Medical Enterprises v. Bowen*, 851 F.2d 291, 294 (9th Cir. 1988):

Because the Secretary's interpretation of the Medicare Act is, by his own admission, contrary to the Medicare regulations regarding accrual accounting, because he has given no basis grounded in the Medicare Act or its regulations for this divergence, and because the accrual accounting regulation is, notwithstanding the Secretary's argument, applicable to the calculation of return on equity, we affirm the ruling of the district court.

Still another case in which the Ninth Circuit applied this principle is *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989), but in that case "[t]he Secretary refused reimbursement on the ground that under [GAAP] (which the Secretary is mandated to apply where an issue has not been covered by agency regulations, 42 C.F.R. § 405.405) there were no reasonable costs incurred." 869 F.2d at 1180. In holding for the Secretary, the Ninth Circuit noted that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply" GAAP. 869 F.2d at 1181.

¹⁷ See *Vallejo General Hospital v. Bowen*, 851 F.2d 229, 233 (9th Cir. 1988) ("In this case the Secretary's actions are adequately supported by the language and purpose of the regulations, so we need not consider GAAP . . ."), *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542 (9th Cir. 1990) (Holding that stock maintenance costs are not "necessary and proper" within the meaning of 42 C.F.R. § 405.451 although such costs are recognized by GAAP); *National Medical Enterprises, Inc. v. Sullivan* ("[C]hallenge to the validity of a regulation promulgated by the Secretary") (Emphasis added).

GAAP turns on whether a Medicare regulation governs payment contrary to GAAP.¹⁸

The Secretary contends that the Court of Appeals misconstrued the requirement of the Medicare Act that the Secretary, in promulgating regulations under that Act "consider . . . principles generally applied by national organizations,"¹⁹

¹⁸ For cases in which the Medicare regulations requiring the application of GAAP governed, see, e.g., *Lexington County Hospital v. Schweiker*, 740 F.2d 287 (4th Cir. 1984) (Secretary's reimbursement treatment upheld because consistent with GAAP); *McKeesport Hospital v. Heckler*, 612 F.Supp. 279, 284 (W.D. Pa. 1985) ("We believe the Secretary's own regulations requiring accrual basis accounting resolves this almost metaphysical problem [of when a cost is incurred]"); *Medical Society of South Carolina v. Heckler* (D.S.C. February 27, 1984) (Medicare and Medicaid Guide ¶ 33,651) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought); *North Shore Medical Center v. Heckler* (S.D. Fla. July 11, 1985) (Medicare and Medicaid Guide (CCH) ¶ 34,991) (Medicare regulations mandating accrual accounting requires recognition of accrued payments in lieu of sick pay although not actually paid in year for which reimbursement sought).

For cases in which Medicare regulations govern over GAAP, see *Palms of Pasadena Hospital v. Sullivan*, 932 F.2d 982, 983 (D.C. Cir. 1991) ("Accrual accounting principles might specify something different, but the Board was concerned with statutory principles implemented by regulations." (Emphasis added)); *Methodist Hospital of Indiana v. U.S.* 626 F.2d 823, 826 (Ct. Cl. 1980) ("The Secretary and his delegate have the discretion to determine that a cost was not reasonable or not actually incurred . . . provided that they do so consistently with existing, general regulatory and statutory requirements." (Emphasis added)).

¹⁹ In fact, the Medicare Act states:

In prescribing the regulations . . . the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations.

42 U.S.C. § 1395x(v)(1)(A). This language has been interpreted as delegating to the Secretary the interpretation of reasonable costs through the promulgation of regulations:

The precise methods to be used in determining how much a provider is to be reimbursed for its services, triggered a great deal of Congressional debate. . . . Congress ultimately chose not to specify

as a basis for determining "that the Act was intended to direct the Secretary to consider the financial accounting principles of 'national organizations,' and specifically GAAP." *Brief for the Petitioner* at 19-21. In so doing, the Secretary completely misconstrues the issue. There is no dispute that the Medicare Act does not require the application of GAAP in every instance.²⁰ The importance of the Medicare Act to this case, however, is the undisputed fact that the Act requires the Secretary to promulgate regulations governing Medicare reimbursement. 42 U.S.C. § 1395x(v)(1)(A). *See, also, Charlotte Memorial Hospital*, 860 F.2d 595 (4th Cir. 1988); *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *National Medical Enterprises v. Bowen*, 851 F.2d 291 (9th Cir. 1988); *Villa View*, 720 F.2d 1086. The more critical, indisputable fact is that the Secretary, in promulgating such regulations, affirmatively elected to mandate the application of GAAP. 42 C.F.R. 413.20, .24.²¹

As recognized by the Court of Appeals below, had the Secretary elected to depart from GAAP with respect to reimbursement for loss on extinguishment of debt, the Secretary

any rigid formulae. Rather it established general statutory guidelines under section 1395x(v)(1)(A) and authorized the Secretary to "prescribe such regulations as may be necessary to carry out the administration of the [Act]. . . ." (citation omitted) (emphasis added).

Springdale Convalescent Center v. Mathews, 545 F.2d 947, 951 (5th Cir. 1977).

²⁰ The Secretary apparently confused the district court below regarding this point, however, as evidenced by the following statement of the district court suggesting that the Medicare Act requires the Secretary to consider GAAP: "Given the structure of these regulations, the requirement in the statute that the Secretary 'consider,' but not necessarily follow without deviation, generally accepted accounting principles, . . . this court cannot say that the Secretary's conclusion that GAAPs need not be followed in all cases is an impermissible interpretation." Pet. App. 32a.

²¹ Therefore, the Secretary contends it can disregard the Secretary's regulations requiring the application of GAAP merely because the Secretary had the option in promulgating the regulations not to require the application of GAAP.

could have and should have enacted PRM § 233.3 as a regulation. While the Secretary has enacted regulations departing from GAAP in other aspects of Medicare reimbursement, the Secretary has not done so with respect to the loss at issue in this case.²²

The foregoing analysis demonstrates that this Court should affirm the decision of the Court of Appeals below because it is fully in accord with the weight of judicial authority interpreting the applicable Medicare regulations.

II. APPLICATION OF GAAP ACCURATELY REFLECTS THE COST OF PATIENT CARE, WHILE PRM § 233 RESULTS IN IMPERMISSIBLE MISMATCHING OF COSTS AND THE YEARS IN WHICH SERVICES ARE PROVIDED.

Hospital aptly briefs this Court that "[a]lthough Respondent has no further expenses or cost reporting related to the refunded bonds, PRM § 233 requires the hospital to report this as a reimbursable expense item in years after the advance

²² *See, e.g.*, 42 C.F.R. 413.134(f) (loss on disposal of assets); 42 C.F.R. 413.17 (costs to related organizations); 42 C.F.R. 413.102 (compensation of owners); 42 C.F.R. 413.106 (physical therapy and other therapy); 42 C.F.R. 405.482 (reasonable compensation equivalent limits or physician compensation). Each of these regulations specifically authorizes a method of reimbursement that departs from GAAP. Also noteworthy is that on October 9, 1991, the Secretary issued a notice of proposed rulemaking entitled "Clarification of Medicare's Accrual Basis of Accounting Policy." 56 *Fed. Reg.* 50,834. The proposed rule, which to date has not been promulgated in final form, would codify as a regulation the following PRM provisions departing from GAAP without support of a regulation: PRM § 2305 (liquidation of short-term liability); PRM § 2146 (vacation pay); PRM § 2144.9 (all-inclusive days off); PRM §§ 2146.2C and 704.3 (FICA and other payroll taxes); PRM § 2144.8 (sick pay); PRM § 906.4 (compensation of owners); PRM § 704.5 (non-paid workers); and PRM § 2162.7 (deferred compensation). The Secretary certainly could, but has chosen to not, promulgate a regulation codifying PRM § 233.